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Series Editor: Masood Zangeneh

Richard Isralowitz
Patricia A. Findley *Editors*

Mental Health and Addiction Care in the Middle East

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Richard Isralowitz • Patricia A. Findley
Editors

Mental Health and Addiction Care in the Middle East

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Editors
Richard Isralowitz
Spitzer Department of Social Work
Ben Gurion University
Beer Sheva, Israel

Patricia A. Findley
School of Social Work
Rutgers University
The State University of New Jersey
New Brunswick, New Jersey, USA

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Preface

Mental health and drug use are deeply embedded characteristics of most societies and nations including those throughout the Middle East. It shows itself in the form of illness, death, crime, war, human suffering, and other conditions that affect quality of life.

There is no shortage of people affected from these conditions, nor is there any shortage of possible prevention and treatment interventions with ameliorative value. However, the uncommon is a multinational, multiethnic group of people coming together, with trust and respect as well as resilience and resolve, to share a common mission of helping people in need.

The chapters written for this book are no heap of parts. Rather, they are a set of experiences and knowledge accumulated from extraordinary experiences worthy of study, modification and replication....over time and across locations.

This book was prepared to share the hope for peace and well-being among decent, caring people throughout the region—their children and future generations.

Beer Sheva, Israel — Richard Isralowitz
New Brunswick, NJ, USA — Patricia A. Findley

Acknowledgments

To my family members—father, mother, brother, children, grandchildren, and wife Sofi who endures. Recognition is given to Masood Zangeneh, editor of this book series, for his support and understanding of the prevailing challenges to promote cooperation in the Middle East. Special appreciation is expressed to colleagues and friends throughout the region and abroad, especially Richard Rawson and others from the Integrated Substance Abuse Programs in the Department of Psychiatry at the University of Los Angeles and the Institute for Disaster Mental Health, State University of New York, New Paltz, who have made this book and much more possible—it has been a privilege sharing a common mission.

In memory of my friend Darwin Telias (Z"L)—a pioneer in mental health and addiction care.

Richard Isralowitz, Ph.D.
Ben Gurion University
Beer Sheva, Israel

To my family who has always supported and encouraged me. Also I dedicate this book to Richard Edwards, Ph.D. and Chancellor of Rutgers University, the State University of New Jersey, New Brunswick Campus. He has been consistent in supporting me and pointing me towards doors, leaving it to my discretion to open the ones I want. I am grateful for the collaborations that Dr. Edwards has brought to me through the introduction to Richard Isralowitz, Ph.D., my co-editor, colleague, and, most of all, friend.

For all those who suffer from mental health and addiction issues in the Middle East, we write with mutual respect and partnership to support their healing.

Patricia A. Findley, Dr. P.H., M.S.W.
Rutgers University, The State University of New Jersey
New Brunswick, NJ, USA

Contents

Contributors

Mohammed Afifi Substance Abuse Research Center, Palestine

Rachel Alvarez School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA

Patricia A. Findley School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA

James Halpern Institute for Disaster Mental Health, State University of New York, New Paltz, New York, USA

Richard Isralowitz Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel

Debra A. Murphy Department of Psychiatry, Integrated Substance Abuse Programs, University of California at Los Angeles, Los Angeles, CA, USA

Alexander Reznik Senior Research Associate, Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben Gurion University, Beer Sheva, Israel

Rebecca Rodriguez Institute for Disaster Mental Health, State University of New York, New Paltz, New York, USA

Orly Sarid Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel

Steve Sussman Department of Preventive Medicine & Psychology, University of Southern California, Los Angeles, California, USA

Karla Vermeulen Institute for Disaster Mental Health, State University of New York, New Paltz, New York, USA

Mor Yehudai Spitzer School of Social Work, Ben Gurion University of the Negev, Beer Sheva, Israel

Chapter 1
Introduction

Richard Israelowitz and Patricia A. Findley

1.1 Introduction

For a small group of Israeli, Palestinian, and US colleagues, the last 20 years reflects a remarkable record of achievement addressing mental health and drug addiction issues in the Middle East—overcoming issues of language, boundaries, and political strife. The contributors to this volume understand that any meaningful response to mental health and addiction must begin with an understanding of the specific nature of the problems, which segment of the population and number of people are affected, and which agencies can help those people in need of assistance. Only by gaining insight of the nature and scope of mutual needs can a rational and effective response be mounted—when possible together or separately.

The Middle East is a region with many events, achievements, and problems that have shaped mankind. The establishment of Israel in 1948 is viewed by some as a considerable accomplishment, and for others it is viewed as a source of injustice:

> There are many issues that divide the citizens of Israel and their Palestinian neighbors. Land, water, religion, culture, justice, identity, economics, and history are all topics that come to mind when discussions of the Israeli-Palestinian neighbors. It is easy to forget that in the midst of these global, centuries old, issues there are millions of people who spend their lives struggling with the same day to day problems that face citizens of other less newsworthy parts of the world (Bogan, 2002, pp. ix–xi.).

R. Israelowitz (✉)
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel
e-mail: richard@bgu.ac.il

P.A. Findley
School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA

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Since the 1980s drug use has come to the forefront as a significant issue that impacts the entire society in Israel (IADA, 2011). In 2011, the Israel Anti-Drug Authority reported that nearly 300,000 people were using drugs in Israel, and 70,000 of these were 12–18 years old, or 11 % of the population. Furthermore, there were about 25,000–28,000 addicts living in Israel at the time (IADA, 2011; Israelowitz & Myers, 2011). Drug abuse affects the Middle East in much the same way it does in Western countries: destructive social, economic, and cultural consequences that impact the equilibrium of the society at large.

It has been more challenging to assess the numbers of individuals in Gaza and the West Bank who abuse substances. However, it is known that substance abusers do exist in these areas despite the condemnation of the use of substances for religious and cultural purposes (Weiss, Sawa, Abdeen, & Yanai, 1999). Over time, it has been shown that Israel has taken a lead on alcohol abuse in its youth, Jordanians addressed illicit drug use, and Palestinians were the last to address the issue, and by the late 1990s, prevention efforts were lacking in any coordinated or collaborative way (Weiss et al., 1999).

In 1996, when Israeli and Palestinian colleagues began discussing drug use concerns, there were few channels of communication open between the two groups and little tangible success beyond what talking there may have been. Through partnership, evidenced in this book, accomplishments have accumulated with support from government agencies, nongovernment, and international organizations, as well as assistance from private foundations and individuals. However, most important is the basis used to promote such efforts. This bedrock has principally relied on two people, an Israeli and a Palestinian; and their relationship has withstood the test of time during periods of peace and conflict. Their commitment to addressing the health and well-being of their communities, separately or together, has been steadfast both often joking with each other that the only factor for certain about their efforts is that nothing is certain.

Global drug use is not a new topic, but it is clear that continued efforts are needed to enhance the evidence base of our treatment methodologies to reduce the numbers of young people who abuse drugs (Degenhardt, Stockings, Patton, Hall, & Lynskey, 2016). Drug abuse can start when a child is 10–14 years old, but the impacts can be as detrimental to these children as they are for adults because these young people are facing role transitions, physiological growth, and psychological development (Hall et al., 2016). The United Nations Office on Drugs and Crime (UNODC, 2014) reports that cannabis, opioids, and opiates are the fastest growing types of drugs being used within the Near and Middle East (UNODC, 2014). The implications of drug abuse on physical and mental health have driven the writing of this book, particularly when thinking about prevention since the global burden of disease that arises from drug and alcohol use is so high and ever increasing (Degenhardt & Hall, 2012). Furthermore, such abuse can inhibit work and economic sustainability of a family and the community (Richardson & Epp, 2016).

1.2 About This Book

Presenting mental health and drug problems may be likened to "craftsmanship." The task of collecting and organizing information from researchers, educators, and others who have knowledge and/or who have developed ways to address the problem is no simple feat. To generate a final product that provides a coherent body of usable knowledge requires skill; it is a time-consuming process for organizers and contributors alike.

The roots of this book, *Mental Health and Addiction Care in the Middle East*, began in 1997 when regional and international experts, including those from the Integrated Substance Abuse Programs, University of California, Los Angeles (ISAP-UCLA) and the World Health Organization, came together to share knowledge about drug prevention and treatment. In many respects, this book and preceding efforts are a valuable source of useable information for policy purposes and intervention strategies in the Middle East region and elsewhere.

The coeditors made no effort to impose comparative perspectives on the contributors. Rather, we juxtaposed knowledge for multiple purposes—that is, we brought information and experience together to show how much the needs and problems of people in the Middle East are the same or different to those elsewhere. The chapters in this book are grouped under two themes: drug use and addiction and mental health and community response in emergency conditions. First, "Drug Use and Addiction" begins by providing a historical perspective of the issue in the Middle East and how events promoted a common understanding and response to drug use across man-made barriers—physical, political, and cultural. This chapter is followed by an explanation of key factors associated with drug use among people at high risk including school dropouts, adults, immigrants, and older people. Next, a key factor promoting a sense of common understanding in the region is discussed—the Substance Use Survey Instrument (SUSI). This instrument has served as a uniform method of data collection and comparison in a setting where, too often, little is comparable.

Cigarette smoking remains a major health problem (US Department of Health and Human Services, 2014). This issue, addressed by a US evidence-based prevention intervention for youth in the region, is discussed. Chosen as a prevention model for replication, it was doomed to fail were it not for the resilience and quick thinking of the US, Palestinian, and Israeli partners involved.

The Middle East is a land of transition, and nothing is more evident of this than the waves of people who immigrated to Israel in the late 1980s from the former Soviet Union. Issues of immigration, acculturation, and drug use are discussed as a chapter—the lead writer, an immigrant who came off the streets of Beer Sheva, Israel, looking for work, announcing to the director of the Ben-Gurion University Regional Alcohol and Drug Abuse Research (RADAR) Center in broken English and Hebrew, "I know drugs and want work," has been an integral part of many of the efforts generated and reported in this book.

"Children of mothers addicted to harmful substances" is a sorely neglected issue. With the support of ISAP-UCLA, a senior in residence professor contributed much

time and effort to help promote understanding of the key issues involved for program intervention. Issues of parenting skills, resilience, and health behavior among mothers at high risk are among the topics that are addressed in this text.

Part 2 of this book addresses mental health and emergency conditions, disaster relief mental health, psychological first aid, and interdisciplinary collaborative approaches to mental health and addiction treatment. These issues brought the coeditors of this book together with the director of the Institute for Disaster Mental Health—State University of New York, New Paltz—to address the mental health needs of people affected by war and violence. Israel has years of experience addressing this issue. However, for political reasons and other factors, limited knowledge has been transferred. US experts bridging relations and promoting useful means of intervention have contributed much in terms of addressing drug addiction and mental health care through training, education, and research initiatives.

Also in the book, the use of psychological first aid (PFA) is discussed as a way to address conflict mitigation among the Palestinians and Israelis. This was an important project that brought together several international partners to train-the-trainer sessions on PFA, but through that process, the goal was to help build empathy among the participants about the shared stresses of living in the Middle East. The book focuses on collaboration and a shared sense of meaning as an underlying theme to address sociocultural, mental health, and addiction care issues.

1.3 Future Directions

In 1996, while on sabbatical at Rutgers University, I met the coeditor of this volume, Patricia A. Findley. Intelligent and resilient with a sense of humor made her a natural for joining the Middle East team. This is said with respect and appreciation for her efforts organizing and putting together this work. In her hands, a heap of parts have come together as a whole—a book that we hope will motivate others, a fresh generation, to leave beyond conflict and hostility and move forward to peace and prosperity. We thank the individuals who have contributed to this book through their participation in the reported studies, training sessions, and interviews.

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Part I
Drug Use and Addiction

Chapter 2
Drug Abuse in the Middle East: Promoting Mutual Interests Through Resistance and Resilience

Richard Isralowitz and Mohammed Afifi

2.1 Introduction

Because Jewish and Arab people have been in a declared and/or de facto state of war since the establishment of Israel in 1948, the possibility of such people to deal with mutual mental health and addiction problems has been remote. Addiction, through mutual law enforcement efforts, information sharing, training, and research have not until recently been considered as an effective strategy to tackle.

A guiding principle of this case study of joint Middle East efforts is that encounters between addiction caregivers, researchers, policy makers, and others including physicians, psychologists, social workers, and academicians can have multiple aims. One is to address local and regional problems through evidence-based interventions. Another is to develop a framework for positive interaction by focusing on a common topic of scientific and public health interest in order to promote communication and cooperation, reducing conflict and hostility.

R. Isralowitz (✉)
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel
e-mail: richard@bgu.ac.il

M. Afifi
Substance Abuse Research Center, Palestine

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2.2 Middle East Narcotics Trafficking, Control, and Need for Positive Interaction Addressing Common Problems

Illicit drug use and trafficking have a long history in the Middle East. In 1959, the Middle East Narcotics Survey Mission of the United Nations was established to make suggestions on the ways to control illicit drugs originating in the Middle East and to guide the United Nations Commission on Narcotic Drugs on the best ways to handle the problem. The Mission considered the drug problem as a regional issue characterized by the production and consumption of substantial amounts of cannabis, opium, and opium derivatives as well as the transport of these substances via land, sea, and air routes to other parts of the world, in particular to Europe and North America (UNODC, 2014).

Cooperation was urged to address the drug problem at the grass roots level including desolate frontier lands and country borders. However, in order to improve cooperation at this level, it was essential to have broad and comprehensive agreements among the neighboring countries involved (Bulletin on Narcotics, 1960). The Mission also noted the value of bilateral agreements between governments. It encouraged direct contact among governments' law enforcement agencies as well as health, education, and welfare ministries and nongovernmental organizations (NGOs) addressing drug problems for prevention and treatment purposes. None of the recommendations were addressed on multinational or People-to-People (P2P) levels until the Middle East Regional Alcohol and Drug Abuse Research (RADAR) centers were established in 1995–1996 by the authors of this chapter through the United States Substance Abuse and Mental Health Services Administration (SAMHSA).

2.3 The Middle East Peace Process: An Overview

To understand the current context of addressing drug and mental health problems among Israeli and Palestinian people, reference must be made of the Oslo Declaration of Principles (DOP) Accord of September 13, 1993. Various agreements including the Israeli–Palestinian Declaration of Principles of September 13, 1997, provided a framework to bring peace, security, and stability to the region. They laid the ideological foundation for cooperation, through joint initiatives in areas of economics, industry, communication, environment, water management, and health, considered to be an integral part of promoting reconciliation and peace.

The People-to-People (P2P) proviso of the Interim Agreement (Article 8 of Annex 6) signed on September 28, 1995, and subsequent resolutions recognized that political leaders alone cannot achieve peace and that networks of change agents and other people with mutual interests need to be established. While politicians may accomplish peace through written agreements, only people can actually make it

happen through efforts and interactions with each other. RADAR Centers, with support from the SAMHSA, the Israel Ministry of Foreign Affairs' Agency for International Development Cooperation, and Ben-Gurion University (BGU) were established to provide "useful information" to people addressing the drug problem and to promote bridge-building initiatives among those involved. This experience, in cooperation with peace organizations, professional agencies, and international experts, created a drugs–peace consortium known as "Palestinian and Israeli People Against Substance Abuse" (PIPASA) in the late 1990s. Over time, the PIPASA relationship became a hotbed of personal interests and conflicting perspectives resulting in disintegration. However, much activity was generated and still continues as the result of people working together in a spirit of cooperation.

2.4 Toward Mutual Interests and Peaceful Relations

During the last 20 years or so, two concepts of promoting peace in the region have come into play. The first is associated with efforts of diplomats and other people to bring about a cessation of hostilities by ensuring cease-fires and finalizing peace agreements. In contrast to peacemaking through diplomacy, peace building involves long-term efforts designed to transform the nature of relations through identifying and addressing mutual interests and concerns among those caught up in a conflict. Cease-fires, peace agreements, peace building, and joint efforts represent different phases of conflict resolution. The approach taken to address Middle East drug use and mental health issues built on select organization components that included (1) an integrated perspective focused on short-term accomplishments for long-term transformation (e.g., initiating activities to address needs, resolving simple concerns immediately, and promoting mutual recognition) and (2) building a constituency of individuals and organizations able to work together and support each other in a spirit of respect and trust during good and bad times (Israelowitz et al., 2001; Lederach, 1995).

As noted above, the participants in the PIPASA experience were not politicians but NGO personnel, academicians, and caregivers. As such, they were not in a position to contribute to efforts that would provide a short- or long-term framework for solving the Palestinian–Israeli conflict. Such a framework was created and attempted with the Oslo Accord peace process and put into practice with interim agreements promoted by peacemaking organizations that were in a position of doling out resources and opportunities for program activity. With such resources, people and projects were sometimes herded together by certain NGOs to further their own interests rather than those of people at ground level.

In the remainder of this chapter, the PIPASA experience is examined in terms of Lederach's principles of building a constituency and infrastructure promoting cooperation and cooperation in the region.

2.5 The Processes and Outcomes of the Regional Alcohol and Drug Abuse Research Initiatives

On the Israeli side, professional drug abuse leadership was provided by the RADAR Center of Ben-Gurion University (BGU). The key Palestinian substance abuse professionals were affiliated with the Bethlehem-based Child and Family Consultation Center (CFCC) and the Gaza-based RADAR Center of the Child Health and Community Research Association (CHCR), now the Substance Abuse Research Center (SARC). These RADAR Centers compiled libraries of educational and reference resources (books, pamphlets, posters, and videotapes). Materials included National Institute of Drug Abuse (NIDA) and SAMHSA documents representative of "best-practice protocols."

Creating outposts. From their start, the Israeli and Palestinian RADAR Centers represented "outposts" for increasing drug abuse awareness in the region. However, over time, the Palestinian West Bank unit ceased to exist for organization reasons including dissonance among personnel. Also, the Israeli and Palestinian NGOs that created opportunities for health professionals and caregivers to meet and interact broke apart. This is not surprising because of the uncertainty of resources needed to promote motivation and initiatives generating a steady flow of short- and long-term results. Also, particularly on the Palestinian side, such cooperation in many cases led to confronting conditions that were affecting careers and, even more so, the well-being of individuals and their family members. In retrospect, the ability to bring Israelis and Palestinians together for professional interaction is as uncertain now as it was 20 years ago. An example is the challenge of arranging travel permits for Palestinian professionals to leave the West Bank and Gaza in order to enter Israel for professional training purposes. Today, few Israelis venture into Gaza, and residents of that area can enter Israel or cross over to the West Bank only after receiving permits from Israeli government security units. Knowing passage is permitted, even with assurances, is often uncertain up to the very last minute making joint workshop and training efforts a daunting challenge.

Workshop. During the initial planning stage of organization (i.e. in the late 1990s), the BGU and Palestinian RADAR Center directors conducted a workshop on the drug abuse problem. The workshop was designed to facilitate a meeting of professionals from both societies and to gauge the extent of cooperation possible. It was agreed that the workshop would be held in Beer Sheva (Israel), home of Ben-Gurion University, and that an international expert from the United States be invited to serve as facilitator between the two groups. With cooperation from personnel of the US Embassy in Tel Aviv and international foundations, a senior staff member of the University of California Los Angeles–Integrated Substance Abuse Programs was chosen to share his knowledge and experience. This was a carefully thought out selection process because the workshop participants needed someone able to promote networking and support of joint drug abuse-related activities.

Lecture series. The initial RADAR Center effort involving the US expert was widened to include a series of lectures in Gaza and the West Bank for Palestinian professionals, prior to the joint workshop in Beer Sheva. The reason for this was to ensure that his trip did not solely depend on the workshop that was in danger of being postponed due to a closure of the Israeli boarder crossings with Gaza and the West Bank. Having successfully completed the trips to Gaza and the West Bank, efforts focused on the 2-day workshop entitled, "Palestinian and Israeli People Against Substance Abuse: An Effort to Address the Problem Through Communication, Cooperation and Coordination." As expected, travel permits for Palestinians to enter into Israel were a problem for the workshop that was to be held (i.e. November 4–5, 1997). Only two thirds of the Gaza workshop participants were granted permits. On the West Bank, two of the key participants were refused entry that prompted the frustrated 18-person West Bank delegation to threaten boycott of the event. Eventually, after a daylong persistent NGO negotiation with Israeli security personnel, permits were obtained for all of the Palestinian West Bank participants. However, the permits did not include sleepover authorization for everyone, causing the West Bank participants to arrive only on the second day of the workshop (Isralowitz et al., 2001).

Despite the workshop getting off to a difficult start as a result of the permit problems, the second day produced electrifying debate, and it soon became apparent that the area of drug abuse encapsulated a world of its own for dialogue and cooperation. One of the major issues raised was the Palestinian claim that Israel deliberately encouraged the flow of drugs to Palestinian areas. This position was linked to two factors. The first was the association between some Palestinian criminal collaborators, often drug dealers and prostitutes, who had worked with the Israeli General Security Service as informants (Robinson, 1997). A second factor contributing to this perception was that drug dealers holding Israeli identification cards, arrested for selling drugs in Palestinian areas, were soon seen on the streets after being transferred to the Israeli authorities. This situation was clarified by a senior representative of the Israeli police who stated that Israeli authorities often had no choice but to release these people because they lacked the evidence to convict and that similar problems were being faced in Israel as a result of liberal arrest laws. The workshops provided a valuable framework to address these perceptions and enabled the participants to stress the importance of research including an assessment of Palestinian needs in the area of skills training. It is worth noting that the American expert played a central role in the Beer Sheva workshop and its discussions by providing a neutral third-party perspective, particularly at junctures when sensitive issues seemed to shift the focus of the workshop to a series of mutual recriminations. A stenographer recorded these and other workshop proceedings for publication and distribution (Isralowitz, 1998a, 1998b, 1999; Isralowitz et al., 2001).

The initial Israeli–Palestinian drug abuse workshop served an important function. It provided participants with an opportunity to establish personal and professional contacts regarding a mutual issue of concern, drug abuse, and addiction, as well as to promote cooperation for information sharing, research, and training workshops. The event served to ensure that the process was practically oriented and that no one side

imposed its will or agenda on the other. The forum also served as a means to dispel a number of misperceptions about the drug problem, reinforce the belief that the problem was of mutual concern, and humanize perceived adversaries.

Building on the accomplishments of the initial workshop, a second effort was organized with support from the US Information Agency (USIA) and the British Council in Tel Aviv. A consultant from the National Crime Prevention Council (NCPC) in the United States was recruited to lead "Prevention and Beyond: A Workshop on Community Based Initiatives," held in Bethlehem, Israel on May 25–26, 1998.

The workshop, with over 60 participants, was easier to organize since travel permits for participants from the West Bank were not required. A variety of new representatives from Israeli and Palestinian NGOs and government ministries attended including those involved with youth, education, drug prevention, and law enforcement (i.e. police) expanding the network of contacts. The participation of the government representatives was particularly significant at the time, considering that government-to-government contacts had tapered off due to the impasse in the peace process. In addition to the professional interactions, the Israelis who slept over in a Bethlehem hotel visited local coffee shops with the Palestinian participants. Again, as in the first workshop, Palestinians expressed the belief that Israel was "flooding" Palestinian streets with drugs, and again, these matters were discussed and diffused, this time by the police officers attending from both sides including the deputy director of the Palestinian Antidrug Authority. This interaction laid the foundation for future police-to-police workshops and cooperation (Isralowitz et al., 2001).

Funding. Support for West Bank and Gaza Palestinian professional drug abuse training was received from the Agency for International Development Cooperation (MASHAV), Israel Ministry of Foreign Affairs. The two 40-h training programs, organized by the BGU RADAR Center with its Palestinian counterparts, were held at Al-Quds University (East Jerusalem) in the West Bank and Beer Sheva. The Al-Quds workshop was led by Los Angeles-based Matrix Institute for the Treatment of Addictions personnel. In the presence of Fathi Arafat, younger brother of the late Palestinian president Yasser and director of the Palestinian Red Crescent Society and Israel Ministry of Foreign Affairs personnel, workshop participants received two certificates of training completion because a certificate showing Israeli involvement caused problems for some. Immediately after the Al-Quds University training, a workshop was held in Beer Sheva for Israelis and Palestinians. This effort involved a scientist of the Programme on Substance Abuse of the World Health Organization in Geneva, Switzerland, and experts from the UCLA Integrated Substance Abuse Programs to help promote Israeli and Palestinian involvement.[1]

[1] The coordination of the Al-Quds University training was the responsibility of a senior faculty member who received his doctoral degree from a prestigious US university. That person was detained by Israeli security soon after the Al-Quds workshop and jailed. Unknown prior to his arrest was that he had a senior level position addressing education and social welfare issues with Hamas (a US State Department and Israeli government-labeled terrorist organization). His Israeli counterpart, coeditor of this book, received an unsealed letter from him, retained to this day, from

After these activities, a fourth workshop was planned to promote dialogue among Israeli and Palestinian law enforcement personnel including judges and police officers addressing the drug problem. This event was postponed twice because the Israeli participants were denied entry into Gaza. Finally, as a result of considerable persistence from Israeli-based NGO personnel, the workshop was held in Ramallah on March 24 and 25, 1999. It was attended by officially sanctioned delegations of the Israeli and Palestinian police and legal experts of the Israel Ministry of Justice. Also attending the workshop were the deputy director of the Israel Antidrug Authority and his Palestinian counterpart, resulting in improved relations between the two antidrug authorities. Unfortunately, Palestinian judges from Gaza including those affiliated with its supreme court did not attend as a consequence of being detained at the border. During the workshop, the alleged role Israel had in supplying drugs surfaced again as a major issue. Despite heated exchanges, the workshop proved to be a constructive forum for Israeli and Palestinian drug enforcement personnel, including police and legal authorities, to discuss common problems.

While previous endeavors created sufficient momentum for a variety of collaborative research and development projects, in retrospect, these efforts were also instrumental in building the confidence and goodwill necessary for this "police-to-police" meeting. To a certain extent, high-ranking Israeli officers were suspicious of an NGO-driven process arguing that the necessary structures for cooperation and coordination were already in place and that there was no need for its personnel to meet with their Palestinian counterparts. However, in reality, poor relations prevailed between the Palestinian National Authority (PNA) and the government of Israel reducing interactions to a bare "reactive" minimum.

In April 1999, again with support from the US Information Agency, an expert from the University of Connecticut, Department of Community Medicine and Health Care, visited the region to conduct training in Gaza and the West Bank. Also, he led a 2-day workshop in Beer Sheva (April 26 and 27, 1999) to promote a WHO substance abuse research initiative (Isralowitz et al., 2001).

In addition to the workshops and training described above, the Israeli and Palestinian RADAR Centers generated other programs and initiatives. These included the development of Hebrew and Arab versions of the Matrix Institute of manualized, step-by-step, drug treatment approach (Note: The Arab version reportedly found its way to other Arab countries in the Arabian Gulf). The manuals were funded by the Palestinian–Israeli–Netherlands (PIN) Research Program administered by the Foreign Ministries of the Netherlands and Israel. Also, the Palestinian RADAR Center in Gaza received computer, audiovisual, and other equipment from its Israeli counterpart at Ben-Gurion University.

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prison explaining his situation. Effort was made to contact him and intervene in his behalf. A major peace NGO was consulted and advised not to become involved because it could jeopardize the ability to promote other activities and efforts among cooperating Israelis and Palestinians. No contact was ever received again. Even senior level officials of Al-Quds University, where he was last employed, disassociated themselves from him and refused to discuss the event.

In retrospect, the "jewel in the crown" of these efforts was the attendance of Israeli and Palestinian delegations at an international meeting of the US SAMHSA RADAR Center directors in Irvine, California—May 3–8, 1999. This effort included recognition of both delegations by the conference attendees and an Israeli and a Palestinian flag presentation by a United States Marine honor guard. After this event, the joint delegation proceeded on to Los Angeles for training and research planning purposes led by UCLA Integrated Substance Abuse Programs personnel supported by the Matrix and Friends Research Institutes. An outcome of this meeting was a proposal submitted to the United States Agency for International Development (USAID)–Middle East Regional Cooperation (MERC) Program for improving drug prevalence monitoring among youth in Israel, Gaza, and the West Bank. Modeled after the US National Institute on Drug Abuse (NIDA)–Community Epidemiological Working Group approach, the initiative received funding support opening the door for sustained joint efforts. Another positive outcome of USAID support was the publication of an edited book that included contributions from Israeli, Palestinian, US, and World Health Organization drug abuse experts. The book, the only one in English, was published in 2002 (Isralowitz, Afifi, & Rawson, 2002).

The professionals involved with this experience have demonstrated a successful and productive track record of accomplishment—working together to address problems common internationally and, in particular, in Israel, Gaza, and the West Bank. This cooperation has prevailed through difficult times including war and ongoing tension in the region. Professional journal articles and conference presentations have been generated, and the Israeli partner is proud to have been called on by the United Nations to recommend his Palestinian colleague for an award in reducing the spread of AIDS in Gaza and the West Bank.

From 2008 to 2013, attention was given to cigarette smoking cessation among Palestinian and Israeli youth. Developed on an "evidence-based initiative" from the University of Southern California, the effort demonstrated resilience of the partnership to overcome significant cultural and situational obstacles affecting efforts to test the intervention (see Chap. 7). After 4 years, "useful information" was generated, and United States Agency for International Development–Middle East Regional Cooperation funded a follow-up study in Gaza, West Bank, and Israel to identify the impact of the intervention and shifting patterns of drug use among youth resulting from regional tension and war in 2014.

From a mental health perspective, since 2011, the Palestinian and Israel partnership has been working with experts from the Institute for Disaster Mental Health , State University of New York–New Paltz and Rutgers University–School of Social Work on capacity development among professionals, parents, and caregivers to address the needs of children and youth in emergency conditions. This effort is described in detail in Findley, Halpern, Rodriguez, and Vermeulen (2016).

After years of "connecting dots" related to meetings, workshop training, proposal submissions, research, and more with their staff members and steadfast international partners, the coauthors of this chapter were given recognition by the US National Institute of Drug Abuse for their "contributions to scientific diplomacy through outstanding efforts in international collaborative research on drug abuse

and addiction" in 2015. To address the importance of low-profile efforts and acknowledgments, the awards were issued without publicity and without joint photographs as to not bring attention to their partnership.

2.6 Conclusion

The over 20-year effort described above is the result of many people coming together to address mutual interests and concerns, usable knowledge (Lindblom & Cohen, 1979), negative stereotyping, and much more. By tapping into drug abuse a mental health issue of mutual concern, this effort has served as an island of sanity and interaction in rough seas. Overall, the multiple short and long accomplishments reflect what is possible and recommended by the United Nations Middle East Narcotics Survey Mission in 1959. However, regional hostilities show how easy it is to unravel what has been done by individuals and groups with self-serving interests including those of a political nature.

The role and involvement of international experts have contributed much to the success of this effort. They have provided professional legitimacy that encouraged the involvement of participants from both societies; they helped focus discussion and energies on issues of mutual concern; and they served as a source of support and encouragement during times of isolation and despair.

In retrospect, one shortcoming of this initiative is that it never became linked to the permanent support needed to create a joint office or secretariat to manage and coordinate activities among the participants involved. However, such support could have been a divisive factor as evidenced by some peace organizations. Also, it is a pity that attention was not given to measuring the 20-year effort in terms of a "meta" outcome.

2.7 Future Directions

In many respects, the Middle East is at the crossroads in terms of international relations, peace, and stability. For Israeli and Palestinian people, there has been no Arab Spring, no Arab–Israeli Spring, and no Spring at all. Can this experience be replicated in other settings and communities that are in conflict? Can drug abuse and mental health issues of mutual concern be used to build bridges? The answer is yes; however much depends on the people involved and their resolve to work together to achieve beneficial results that are difficult to secure and even more difficult to sustain.

In sum, much has been accomplished; much remains. In the words of Edward Everett Hale, what can be said is:

"[we] were only one, but [one]. We could not do everything, but we did do something. The something we needed to do, we tried to do. And by the grace of G-D, we did and will continue to do so…" [for our children—Israeli and Palestinian].

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Chapter 3
Drug Use Among High-Risk People: Resistance and Resilience Factors

Richard Isralowitz and Alexander Reznik

3.1 Introduction

Much progress has been made over the past few decades in understanding basic factors and developmental processes associated with drug use, abuse, and addiction and the best methods of prevention and treatment services. The initiation of illicit drug use is a necessary precursor to abuse and addiction. Illicit drug use tends to develop during the adolescent years, and the behavior is often preceded by biological, psychological, social, and environmental factors that originate as early as the prenatal period. Misuse and use of illicit drugs can interfere with the normal healthy functioning of persons across the life-span—extending well beyond adolescence into adulthood (NIH, 2011). Figure 3.1 provides a view of these general factors affecting mental health and addiction-related behavior.

The life course developmental perspective suggests that individual and environmental factors interact to increase or reduce vulnerability to drug use, abuse, and dependence. Vulnerability can occur at many points along the life course but peaks at critical transition periods … [including] important biological transitions, such as puberty; normative transitions, such as moving from elementary to middle school; social transitions, such as dating; and traumatic transitions, such as the death of a parent. In addition, because vulnerability to drug abuse involves dynamic intrapersonal (e.g., temperament), interpersonal (e.g., family and peer interactions), and environmental (e.g., school environment) influences, prevention intervention … must

R. Isralowitz (✉)
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel
e-mail: richard@bgu.ac.il

A. Reznik
Senior Research Associate, Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben Gurion University, Beer Sheva, Israel

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Fig. 3.1 Contributing factors to mental health and well-being. Used with permission from World Health Organization (WHO 2012). Risks to mental health: an overview of vulnerabilities and risk factors. http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf Accessed 06 July 2015

target individuals and social systems across the life-span … [and consider co-occurring factors including] delinquency and criminal behavior, interpersonal violence, mental health problems and HIV, other sexually transmitted infections, and reproductive health problems (NIH, 2011).

Underlying this explanation are a host of biomedical, psychological, and/or sociological considerations such as history of drug abuse patterns and the changing population of users; recognition that specific drug abuse patterns are culturally determined as cultures (and subcultures) differ in the availability of drugs and the extent of abuse; awareness that demographic characteristics of abusers vary over time and across location; need to delineate the specific drug (or drugs) of abuse, route of administration, and length of dependence; etiology of social context in which drug abuse begins; influence of major institutions (e.g., family, community, peer group, schools, and media) upon the onset and continuation of drug dependency; drug abuse is more prevalent in certain populations than others; and determination of institutional supports that promote successful treatment and rehabilitation, including consideration of how persistent behavior in subcultures can be changed (Ball et al., 1995; INCB, 2010, p. 2–6).The following issues shape drug use, abuse, and addiction. Also, they determine the nature and scope of resilience and resistance to drug use.

3.1.1 Social Order

People are often referred to as deviant when they do not share the values or adhere to the social norms regarding conduct and personal attributes prescribed by society (Goode, 2007). Although the process of identifying deviance involves the use of normative definitions that may vary over time, the essential nature of deviant behavior is that it reflects a departure from the norms of a particular society.

3.1.2 Social Forces: Physical Environment, Values, and Morals

From research conducted as early as the 1920s in the United States, it has been shown that the environment where a person lives can be an influential factor in the use and abuse of drugs. An environment that is deteriorating and poverty-stricken serves as a breeding ground for problem behavior such as drug use. Living in these conditions are people from the lower end of the social hierarchy, who are often beset with a huge assortment of personal and family problems. In order to exist, norms and values different from those prescribed through explicit and implicit social policies, laws, and methods of enforcement are adopted by these people, enabling them to achieve goals that are readily attainable and concrete.

3.1.3 Ethics, Values, and Morals

Although issues such as values and morals among the lower classes and the disproportionate amount of crime and drug problems found among the poor have been widely covered by sociological research and literature, studies show that such problem behavior is also indigenous to the middle and upper classes. Facts and statistics reveal that drug use and abuse is a problem that transverses all social classes (Israelowitz, 2002; Miller, 1958). However, it is a problem that tends to be more easily rooted among poor people in conditions of poverty and social degradation and the social reality defined by politicians, law enforcement officials, police, and other decision-makers.

3.1.4 Interpersonal Relations

3.1.4.1 Family

The role of the family is a major causal factor in shaping the personality and behavior of children. The family serves as a reference group on personal and normative levels. Family shares responsibilities with social institutions and peers as a major socializing influence. Parents train their children to conform or not to conform to particular moral standards through the examples they provide by their own behavior. Investigators of families with a drug-abusing member have identified some consistent patterns related to adolescent drug use, including the role of mother and/or father to their child. Research shows that family relations; parental roles; divorce; parent and sibling alcohol and drug use; death or absence of a parent; emotional, physical, and/or sexual abuse; mental health; low aspirations; and other factors are linked to drug use (Glynn & Haenlein, 1988).

3.1.4.2 Peers

Peer relations are often linked to drug use (Goode, 2007; Isralowitz, 2002). Such behavior may be learned through association and interaction with others who are already involved with drugs. A person's relationship with peers may serve as a means of escape from other interpersonal dealings such as family, school, or work. Peers tend to have a consistent influence on health-risk behavior and may be better predictors of such behavior than parental influences among young adolescents. Studies show that a high level of adolescent peer activity predicts drug use (Isralowitz & Myers, 2011). The more young people are isolated and alienated from their parents and the more involved they are with peers, the greater the likelihood that they will experiment with drugs. Users tend to be friends of users, and the selective peer-group interaction and socialization constitutes the single-most powerful influence related to drug use among young people regardless of social class (Kandel, 1980; Needle et al., 1986). Strong bonds to family, school, and religion, however, usually decrease the influence of antisocial peers and problem behavior including drug use (Isralowitz, 2002; Isralowitz & Reznik, 2015).

3.1.4.3 Education

School is a major agent of status definition in society and has a critical role in the socialization process. The school labels youth as winners or losers and by so doing frequently determines the directions they take that may involve the use of drugs.

Many studies have shown a strong relationship between a negative school experience and drug use. For example, negative attitudes toward school, low academic aspirations and educational achievement, and disciplinary problems in school often precede the onset of drug use and/or dropping out of school. Furthermore, teenage pregnancies and frequency of school absenteeism are associated with increasing levels of drug use. The educational process, the school, and its personnel are a potent force in terms of shaping the attitudes and behavior of youth. Too often, however, the full impact of the school's resource base is lost. Communications between teachers and parents, particularly in the areas of strengthening and reinforcing the learning processes of youth during nonschool hours, tend not to be emphasized (Isralowitz, 2002; Smith, 1975).

3.1.4.4 Media

Since the 1920s when motion pictures became a major source of mass entertainment, the effects of the media have been subject to scientific inquiry and public concern. The media has an influence on the socialization process and, in turn, on drug use and related problem behavior (Isralowitz, 2002). American children and adolescents spend an average of 3–5 h/day with a variety of media, including television, radio, videos, video games, and the Internet (Strasburger & Donnerstein, 2000).

Behavior such as drug use in the media can have a lasting effect on children and youth if the themes presented are repeated often enough and if the behavior is not clearly contradicted by significant others, such as parents, peers, or teachers.

3.1.4.5 Labeling and the Criminalization Process

The labeling process is a method that determines a person's fate (Becker, 1953). It tends to reinforce problem behavior rather than ameliorate it. Essentially, labeling theories are less interested in a person's problem behavior and characteristics than in the criminalization process—apprehending and punishing law violators and leaving them with a negative status. In terms of drug use, a consistent pattern of events tends to take place, resulting in a feedback cycle involving more deviations, more penalties, and still more deviations (Israelowitz, 2002; Schrag, 1973). Hostilities and resentment are built up and culminate in official reactions that label and stigmatize the drug user, thereby justifying even greater penalties and restricting opportunities for the person to change problem behavior. The roots of the labeling and criminalization process go right to the heart of a major controversy regarding the drug scene—that is, the belief that the judicial and law enforcement decision-making process underlying the drug problem is racially biased. In many city neighborhoods, black men have nearly a one-third chance of being incarcerated at some point in their lives, and the majority without a high school diploma has spent time in prison by the time they reach their mid-30s (Herbert, 2010).

3.2 Biological and Psychological Characteristics

3.2.1 Biological

Research shows genetic factors contribute from 40 to 60 % of a person's vulnerability to addiction, but this includes the contribution of combined genetic-environmental interactions (Dick & Agrawal, 2008). Drug addiction is a brain disease. It is a chronic illness. Although initial drug use might be voluntary, once this addiction develops, control is markedly disrupted. It has been found that genetic influences are stronger for abuse of some drugs than for others and that abusing one category of drugs, such as sedatives, stimulants, opiates, or heroin, is associated with a marked increase in the probability of abusing every other category of drugs. Heroin is the drug with the greatest influence for abuse (Tsuang et al., 1998; Volkow, 2005). Another theory postulates metabolic imbalance as a possible cause of drug abuse—specifically, narcotic addiction. Whether drug users and abusers are at higher risk of suffering some metabolic imbalance is not widely known.

3.2.2 Psychological

Psychological theories associated with drug use may be categorized into two groups—those that emphasize the mechanism of reinforcement and those that stress personality differences between people who use and are dependent on drugs and those who abstain. Research shows that drugs have addicting reinforcement properties independent of personality factors—and this reinforcement can be positive and negative. Positive reinforcement occurs when a person receives a pleasurable sensation and, because of this, is motivated to repeat what caused it. Negative reinforcement occurs when a person does something to seek relief or to avoid pain and to feel normal (Goode, 2007).

Personality pathology, defect, or inadequacy is another theoretical approach (Israelowitz, 2002). The inadequate personality approach posits that the emotional or psychological nature of certain people leads them to drug use. Drugs are used to escape reality and avoid problems. This personality type lacks responsibility, independence, and the ability to defer pleasurable gratification for the sake of achieving long-range goals. Other personal characteristics include low self-esteem and feelings of self-derogation brought about by peer rejection, parental neglect, school failure, impaired sex-role identity, ego deficiencies, low coping abilities, and coping mechanisms that are socially devalued and/or are otherwise self-defeating (Petraitis, Flay, Miller, Torpy, & Greiner, 1998). Other characteristics include being less religious, less attached to parents and family, less achievement oriented, and less cautious as well as having a higher level of sexual activity.

3.3 High-Risk Populations: Israel

3.3.1 Youth: School Dropouts

Drug use, school dropout, and other behavior problems among youth in many countries continue to grow and make headlines (DuPont et al., 2013). The high level of drug use reported by such youth is not surprising since their backgrounds reflect school failure, delinquent and criminal behavior, and other related factors linked to those described above in the theoretical section of this chapter (Cohen-Navot, Ellenbogen-Frankovits, & Reinfeld, 2001; Israelowitz & Reznik, 2007; Israelowitz, Reznik, & Straussner, 2011; Rumberger, 2004). A higher level of alcohol and drug use among females than males is consistent with patterns evidenced in many European countries (EMCDDA, 2005; Israelowitz & Myers, 2011). This detail supports a growing literature on female-specific treatment needs and approaches including early intervention both in school before girls drop out and with their families (Tuchman, 2010).

Information on school dropouts is sparse; in part, this is because most don't receive assistance. For example, in the United States, it has been reported that 21.6

million persons (8.2 % of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year. The number in 2013 was similar to the number in each year from 2002 through 2012 (ranging from 21.6 million to 23.6 million) (SAMHSA, 2014). Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs, 4.3 million had dependence or abuse of illicit drugs but not alcohol, and 14.7 million had dependence or abuse of alcohol but not illicit drugs. From these numbers, it is important to note that among the 21.6 million persons needing treatment for an illicit drug or alcohol use problem in 2013, 20.2 million persons (nearly 94 %) did not receive treatment at a … facility in the past year. (SAMHSA, 2014, p. 93–94).

The Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben-Gurion University, conducted a study of Israeli youth who, for the most part, dropped out of school with an addiction problem. These youth, approximately two-thirds male, were referred by probation, social service, and healthcare workers to a residential facility for drug treatment from 2004 to 2013. During their intake interview prior to treatment, the following information was collected[1]:

- Significantly higher level of last 30-day drug use before residential treatment was reported by females.
- Country of origin (i.e. mother's place of birth—Israel and former Soviet Union) was not a factor that differentiated high-risk youth in treatment for drug addiction.
- Significant predictors of last 30-day drug use include ability to access drugs and problem behavior including fighting, stealing, weapon possession, decline in school achievement and interpersonal relations, and unsupervised evening/night activities.
- Over time, there has been downward trend in terms of the ability to access drugs.

3.3.2 Prescription Drug Use Among Young Adults

Prescription drug abuse is a major public health concern and the consequences continue to mount; the cost in human lives lost is tragic and the cost to society growing. One of the most disturbing trends to emerge is the number of young people initiating their drug use with prescription medications containing a controlled substance (EOP, 2012; 2012). The reason for this drug problem and serious public health concern is because prescription medications have become more widely available and easier to obtain; it is an issue of concern worldwide.

Often times, individuals receive prescription drugs from a friend or relative for free. Other methods of obtaining such drugs include making multiple visits to different

[1] Here and below we don't present the results of statistical analysis. For more information about statistical data, please contact Dr. Alexander Reznik, Ben Gurion University (Reznikal@bgu.ac.il).

physicians for the same health claim, visiting physicians or clinics known to be "prescription mills," stealing or forging prescription pads, changing the dosage amount or number of refills indicated internet sales, or purchasing smuggled or stolen drugs (Isralowitz & Myers, 2011).

Prescription drugs are usually used for legitimate medical purposes. However, many physicians are not well educated or experienced about drug use and abuse, and there are physicians who readily prescribe prescription drugs for pain relief without understanding the consequences and harmful effects such use may have on a client's behavior and well-being (Glajchen, 2001).

Opiates and opioids (i.e. narcotic analgesics or pain relievers) are commonly used prescription drugs. These include hydrocodone and oxycodone with brand names such as Vicodin, OxyContin, Percocet, and Percodan. Tramadol, a synthetic opioid developed by a German pharmaceutical company in the late 1970s, is also commonly prescribed for moderate and severe pain relief despite overstated manufacturer claims about the efficacy of the drug and understated information about the serious risks associated with its use that include abuse and addiction. This drug is commonly available in Gaza among Palestinian people (Progler, 2010).

Most information about nonprescription and prescription drug use among youth and young adults is based on school or national surveys and has been previously noted in this chapter. Generally, based on research in Israel, Europe, and the United States, females, especially young adults, tend to have a higher rate of prescription drug use than males (EMCDDA, 2005; Isralowitz et al., 2011; NCADD, 2014).

Most parents are not involved with the prevention and treatment issues of drug abuse and addiction (Isralowitz & Myers, 2011). Research, publication, talks, lectures, and workshop offerings do not prepare oneself for a real-life situation unless that person is directly dealing with the problem. Young adults in Israel, for the most part, are obligated to do military service—for females normally 2 years. The following is the true story of "N" caught up in a cycle of medical mismanagement leading to problematic prescription drug use.

The Story of "N": *A Case Study*. Assigned to a unit with "combat status" and responsible for monitoring security, "N" was injured in a training incident that resulted in dislocated ribs—an injury affecting her breathing, sleep, physical movements, and other personal functions. A sneeze or cough is, understandably, a painful experience. Hours after the accident, and in pain, "N" was advised to travel on buses from an isolated naval base to a regional medical center. There she was examined and provided opioid pain killers. Little did she know about the serious path she was being taken down—a path affecting her physical and mental functioning … she was entering the twilight zone or "zombie land" of personal functioning. Over time, military physicians continued to address her pain with prescribed narcotics. "N" reported that she received enough medications to set up a pharmacy.

Examination after examination, in Haifa, Tel Aviv, Jerusalem, and Beer Sheva, evidenced N's medical problem. Some physicians prescribed more narcotics; others advised her to stay clear of such use because of the harmful effects. Ordered to return to her security monitoring position, a commanding officer reviewing her situation labeled her "an addict, a junkie" in need of getting control over her life and

needing to learn pain management. A young person committed to national service had been put on the path of narcotic prescription use by her physicians.

"N" is not alone for sure. There are many others who are given narcotic prescription drugs by physicians—some exercising care and concern, and others using such drugs as a quick fix and out the door remedy for pain management. Fortunately for "N" she had support and guidance on how to deal with her use of prescription drugs. Others are far less fortunate.

Without proper monitoring and follow-up, well-meaning physicians may be contributing to a growing population of "legitimized" drug abusers in need of medical, psychological, and social work supports in order to maintain a "normal" lifestyle. There is no hiding from this problem, it is serious and intervention measures are needed to prevent its growth as a major issue of concern and cost—cost to the individual, family members, and society.

As a personal note, there are many experienced and well-meaning people able to provide support in such matters. However, from experience, it was the placement of N in national service that provides young adults with an option of military service that helped pull herself together with self-confidence and motivation to move forward with her life. N and her family were the lucky ones … many are not.

3.3.3 Women

Considerable progress has been made toward understanding illicit drug use. However, the problem related to females has been recognized as being sorely neglected (Isralowitz & Myers, 2011). The reasons why drugs are used differ between males and females. Females are more vulnerable to abuse and addiction—they become more dependent on drugs, such as crack cocaine, faster and suffer the consequences sooner than males.

A particular stressful event is often cited by women as a reason for initiating the use of harmful drugs. Studies show that females who abuse drugs have problems related to co-dependency, a history of parental alcohol and drug abuse, incest, and physical and sexual abuse—up to 70 %, victimization, sexuality, and relations with significant others (Isralowitz & Reznik, 2008). Also, many women are faced with the need to deal with serious health and mental problems such as poor nutrition and below-average weight, low self-esteem, depression, preterm labor or early delivery, and medical and infectious diseases such as increased blood pressure and heart rate, sexually transmitted diseases (STDs), and/or HIV/AIDS (NIDA, 2009). Socioeconomic factors are viewed as related both directly or indirectly to drug abuse by women.

Women begin abusing drugs later than men and they are more likely to have a coexisting psychiatric problem such as depression; report a greater history of suicide attempts; and tend to be more hostile. Many women report that their drug-using male sex partners initiated them into drug abuse. In addition, drug-dependent women have great difficulty abstaining from drugs when the lifestyle of their male partner is one that supports drug use (Isralowitz & Reznik, 2013).

Many drug-using women do not seek treatment because they fear not being able to take care of or keep their children, reprisal from their spouses or boyfriends, and punishment from authorities in the community (Israelowitz & Reznik, 2013). Among those in need of treatment, many are faced with addressing a range of issues like life with an alcoholic or addicted male partner, a lack of education, job experience, self-esteem, and assertiveness skills, making it difficult for them to manage the complex treatment and assistance network (Straussner & Brown, 2002).

In many developed countries, drug abuse is no longer a predominately male activity. Among European countries, it has been reported that understanding drug use by women is a critical requirement for effective prevention and treatment responses to their needs (EMCDDA, 2005; Israelowitz & Bar Hamburger, 2002). Among key issues for women are barriers to treatment access. The lack of social and economic support and childcare obligations have been identified as factors that can inhibit women from making use of drug treatment services. Also, women may be disinclined to enter inpatient treatment services, where they often represent an even smaller minority of clients than they do in outpatient services (Israelowitz & Bar Hamburger, 2002).

3.3.3.1 Low-Threshold Facilities for Women

Low-threshold agencies (i.e. agencies or services that help drug addicts with daily survival and help avoid their further deterioration) are available in a number of countries. They usually involve outreach, information and advice particularly about safe sex, provision of sterile injecting equipment, condoms and lubricants, and referrals to further health, social, and treatment services without imposing abstinence from drug use as a condition to service access. Also, this service may include comprehensive healthcare and counseling (EMCDDA, 2005; Gervasoni, Balthasar, Huissoud, Jeannin, & Dubois-Arber, 2012).

3.3.3.2 Focus on Sexual Health and Pregnancy

Outpatient and low-threshold facilities increasingly include basic medical care and have orientated service provision for sexual health, contraception advice, and free infectious disease testing and treatment, as well as pregnancy tests. Pregnant drug users are defined as a priority group and staff members help them to “jump” the drug treatment queue. An approach to pregnant drug users that has gained ground across Europe is to provide integrated quality care. Here, staff members support women in gaining access to a range of appropriate services. It has been reported there may be as many as 60,000 pregnant women using opioids and other drugs. Therefore, the issue of pregnancy and drug use is important to address for the mother, the unborn children and public health reasons (Gyarmathy et al., 2009).

Up to the 1990s, scant information was available on former Soviet Union (FSU) and Israeli origin female addicts (Isralowitz & Borkin, 2002; Isralowitz & Reznik, 2009, 2013). After nearly two decades of research, the following has been found:

- FSU females tend to be younger, less likely to be Jewish (a status that affects government benefits to immigrants), more likely to be married, better prepared for work through specialized training, and employed than their Israeli counterparts.
- Immigrant and native-born women report similar rates of being victims of sexual and physical abuse.
- FSU women report significantly more chronic medical problems including hepatitis C and HIV/AIDS than Israeli origin females.
- Alcohol and opiate use are higher among FSU women; Israeli-born women use more cocaine and sedatives.
- FSU women prefer shorter forms of treatment intervention such as detoxification and are more inclined to use alcohol and other drugs while receiving treatment.
- FSU women have a greater concern about their personal health and maintaining custody of their children (Isralowitz, 2003; Isralowitz & Bar Hamburger, 2002; Isralowitz & Borkin, 2002).

Nika's Story. The following story about "Nika," a former Soviet Union immigrant and drug user, is true. The story reflects the interaction of individual and environmental factors that influenced her vulnerability to drug use, abuse, and dependence. Born in 1978, Nika emigrated from Leningrad (now St. Petersburg) to Israel at the age of 22. The interview was conducted by a senior researcher of the RADAR Center, Ben-Gurion University, with permission and proper safeguard to her confidentiality. The interview has been edited for this chapter.

The Early Years. After many years of trying to became pregnant and give birth, my mother succeeded. I was born after 10 years of trying but believe my parents had no real desire to have a baby. My father was an editor of one of the Leningrad's newspapers and my mother worked as an accountant for a restaurant in one of the train stations … They had a pretty good life and were together for 10 years.

My father wasn't an alcoholic but he loved to drink … He had a good job and a positive outlook toward his career. My mother was always there for him and for him only … she treated him as if he was a big child. When I came into his world all the romance and intimacy of their relationship disappeared and then the problems began. They divorced 2 years after my birth.

My father called me once a year on my birthday but we never met even when I visited Russia. He was making good money but never provided support for my mother and me. My mother went on to marry other men. The first was wonderful who I wanted to be near when I was 4 and 5 years old. Mother was suspicious of our relationship. I remember how we were lying very close and tight to each other once; … in that moment my mother came in. She had a very strange look on her face. I don't know any of the details but soon afterward he was gone. Afterwards, she had 4 other husbands. There was one, a military man, who was strict and who

I did not get along with … after a couple of years he left the house. The third one was a married man; he was in a constant process of leaving his wife but eventually didn't. When my mother understood, after 2–3 years, that he was not going to divorce his wife, she left him. Afterwards, my mother was alone for many years and then remarried again. I lived with my mother in a two bedroom apartment—one room was my mother's, the second was mine and a living room. To be honest, I was sleeping with my mother most of my life when her men were not in the way.

My school life was fine and from the first grade 3 girls remained my closest friends to this day. After I finished the 7th grade I joined a children's choir and was able to travel to many European countries. I studied English but it didn't come easy and I had a hard time getting into the university. Mother saved money and bribed my way in … after 2 years and failing grades, I was expelled. The real reason was that after the first year at age 19, I "messed up" with drugs, then my life began to come apart.

Alcohol and Drug Use: *The Start*. I began to drink when I was 15 years old with girlfriends. We would buy something cheap like port wine. It was a big bottle, more than enough for us to "get wasted" and then go out to the city. When I got drunk it was fun … We didn't drink a lot, it was just for the good mood before going out … I remember drinking a bottle of liquor in the house, getting drunk, and nearly passing out when my mother and her husband went out for a few hours … When I got older, age 17, my mother and I occasionally had a drink together.

My mother smoked so when I was 13, I secretly tried a number of times but I was fooling around not really smoking—you fill your mouth with smoke and then blow it out without breathing in the smoke. I began to really smoke at 17. When I started smoking I decided not to hide it from my mother. I simply asked if I could join her for a cigarette. She was very surprised and tried to change my mind about smoking at first. But then, she got used to it. Besides smoking cigarettes and drinking, I used marijuana after graduating high school—several times a month with friends including guys who were drug addicts my age who I grew up with in the same building.

Friends. Through high school I had only girlfriends, but after graduation when our "grown-up" life began, we all chose different paths. I made friends with boys as well. The first boys I had as friends were three drug-addicted neighbors. I had a friendship with them, nothing more. I spent a lot of time with them, we regularly traveled together, went out of town or swimming. With them I began to smoke marijuana. They didn't keep secrets from me and I was aware that that they didn't smoke only marijuana but also used "cherniah," that is, black opium. They cooked it by themselves and then used it. Several times I came with them to Dybenko Street, the city market to buy supplies. I saw how they cooked it several times. However, they didn't use it when I was around. After a while they began offering me to try it with them.

I held myself for almost a year refusing their offers time after time. Then somehow I threw it all away—they never stopped bugging me so I gave it a try … We took the train to a suburban town where they occasionally bought "cherniah" for themselves. Then we walked for long time until we came to a house where they cooked it and used it in front of me. When I saw the needle I was shaking from fear … they

injected themselves and then began to try to inject me but could not find the vein. Initially they tried to find a vein in my arm but it did not work; then they decided it would be better to try in the leg but it too did not work. I could not stand it anymore and I burst into tears and began to swear at them and they left me alone. For more than a year they heard me say "no," but when I finally said "yes," nothing happened. If you meet drug addicts on a daily basis and you're constantly offered to try it yourself, sooner or later, even if it takes years, you give up and accept the offer to use at least for the sake of being left alone or out of curiosity.

About a week later I went to visit one of them in his house. This time we didn't go anywhere, it was in our building. He and another friend told me "let's go," found my vein and injected. I didn't feel a thing; I sat with him and the other one for an entire hour. They saw nothing was happening and offered me marijuana to smoke. They told me that after the marijuana it would start. So we smoked and decided to go outside for a walk. When we got to the elevator there was another neighbor of mine from my floor. He looked at me in a very strange way so I understood that something was wrong with me. When we got out of the elevator and went outside I fainted and fell down. Afterwards I felt very sick and told myself enough experimenting. I said to those guys that they should stay away from me with their cherniah and not offer me again.

Soon after that time I met a new guy and we started dating. We developed a more serious relationship. He was a rich kid; we started to go out to nightclubs, discos, and various "hangouts." My period with the neighboring friends was over but a new period was just beginning, I started sniffing heroin. The first time I was offered to try was by my boyfriend. I knew already what it was and that it was "cool" and popular. Thanks to him I meet many people who also used it. I envied them; near them I felt like a little girl who didn't know anything about this lifestyle. Therefore, when he offered me I accepted without hesitation. I calmed myself by thinking that to sniff is not the same as to inject; injecting is dangerous, but to sniff a couple of times—why not?

From the first time, at age 20, using heroin made me feel spaced out. I began sniffing and everything went well. I was sniffing only with my boyfriend but we didn't see each other every day. Because of his job, as a steward on a passenger steamship, we wouldn't see each other for almost 2 months. During these periods I renewed my relations with my drug-addicted neighbors. It turned out that during the time we weren't in touch they switched to heroin. When I found out that they were using heroin, I started injecting together with them. That's the way it continued; when I met my boyfriend I sniffed heroin and when he was away I hooked up with my neighbors and injected with them.

I was still in school, the university, but it was far from being a top priority. I started using a needle on a regular basis. There were withdrawal periods but worst of all was what was after the withdrawals stopped. I had enough strength to deal with the withdrawals but the really hard part was what came after. Everything seemed gray and dull; my legs were taking me to my neighbors for another shot and then it would start all over again.

Thanks to my boyfriend I tried everything—ecstasy, "trip or LSD," and mescaline. I don't even remember what else. But I was craving only for heroin, nothing else, no marijuana, no alcohol, just heroin. In the beginning I was selling my videotapes then it was the gold—4 thin gold necklaces, my mother's and mine.

Addiction, *Abortion*, *and Alcohol*. It was a very tough time for me when I was 20–22 years old. At home there were always scandals that ended with my mother in tears. I broke up with my boyfriend, I was tired of "going out" and sniffing heroin was not enough for me anymore. I was expelled from the university in spite of a second chance. I didn't have enough money for heroin so each morning began with visiting and calling my friends, neighbors and relatives to get loans for my drug. The loaned money was returned by my mother. Sometimes she returned the money and sometimes she did not, she wasn't a millionaire you know. Anyway, I did what I could in my situation. My drug-using friends also managed with whatever they had. During the winter we would rob summer houses; we took whatever we could carry and sell even if it was for a few pennies. They were already in the "system," hooked and not able to survive 1 day without the needle. I too was moving in this direction. Mother would give me money for groceries so I would go to the supermarket with one of my friends and steal what was needed to buy. If we didn't manage to steal one thing, we would take something else and tell my mother that it wasn't on sale so I replaced it. Then we would both go and buy heroin.

I tried to get treatment during that time mostly at my mother's urging. The first time was 6 months after I started using. My mother was reaching her own conclusions, but until the very end she refused to believe that I was injecting. The final straw was when she caught me cooking my portion in the kitchen. When she saw the syringe she raised a cry and started telling me stories about drug addicts. I reacted very calmly and told her exactly what I am and that her shouting would not change a thing.

Even after I told her myself, my mother refused to completely believe it. She went to speak with the parents of my neighbor who I was using with. His parents knew for a long time already. Afterwards, she locked me inside the apartment. After 6 h I had such a withdrawal that I can't even put into words. I was aware of what was going to happen but my mother saw it for the first time … she was very scared and called an ambulance. They gave me a painkiller and I felt a little better. The next day my mother invited a narcologist who gave me an IV and I slept for a few days. I woke up feeling empty and confused. I couldn't understand what was happening to me. I had been in this condition for 5 days and felt that I couldn't bear it any more. I had no life without heroin so I went back to my friends and used again. Afterwards, there were seven more attempts to quit and each one ended the same way. I would manage to go through the hard withdrawal but a few days after I would start all over again. The longest time that I was clean was 8 weeks. I realized that I simply didn't want to live without heroin. I wasn't in a state of "I can't quit." I was in the state of "I don't want to quit." I realized that it was my choice and path.

The idea of immigrating and starting over didn't happened instantly. When I turned 21, after another unsuccessful attempt to quit, my mother sent me away to

my relatives in Odessa. I hadn't been there for almost 7 years. I had a 3rd grade cousin there the same age. When I arrived I saw how he had grown and I started living with him. At first, I slept with him in the same bed. They didn't have another place for me and I didn't want to sleep on the floor. Afterwards we started to date; we went out together and he showed me the city. Then after some time I found out that I was pregnant; it was a big surprise for me and for him. Besides that, I didn't have my period from the time I started injecting. I saw that I was gaining weight but thought it was the effect of the vacation in Odessa. I remember I told my mother: "look how Odessa affected me, how well I look." And then, I do not remember for what reason, my mother and I were in the health clinic. We passed by the gynecologist's office so my mom suggested to get in. It turned out that I was 4 months pregnant. I was happy to hear this news and also my mother, but when we arrived home and started to think rationally about what happened and how my lifestyle would affect this unborn child. Nevertheless, after another withdrawal and short break I started to use again. Mother and I decided that the best thing to do was to abort. I regretted this decision and blamed her. From that time we fought a lot and I began using even more heroin. I regret it happened this way. Maybe if I had the child I would have had motivation to quit using. The doctors didn't say anything about drug use and pregnancy but I stated using birth control methods.

I used heroin constantly and drank intensively so there was no place for pregnancy with this type of life. This went on for another year until I heard about a miracle drug that could help me quit without experiencing withdrawal symptoms. It was very expensive but many of my acquaintances started to use it to quit with the needles. I was very tired and exhausted; the abortion left an impact on me. I still can't talk about it calmly. I decided to try this miracle drug and after a week I realized I could stop using without feeling any withdrawal. To prevent my craving I began to drink strong beer. Every time I woke up I would drink a sip of beer and then go back to sleep and that's the way my days went. During that time I met a guy and we together decided to quit using but to prevent the cravings we often got drunk. My mother and his parents were willing to do anything to prevent heroin use. Their approach was it is better to drink.

Immigration, Absorption, and Acculturation. At this time, my father told me about immigration to Israel during our yearly phone call for my birthday. I was a daughter of a Jew and I had the right to immigrate there. I didn't give it much thought at the beginning because I was studying at the university and just began to use drugs. When I decided to quit, I went to a meeting with the Israeli consul. He asked me to come back after a month with all the required documents. When I went to meet him again, he asked me some questions and I filled up some forms. Then someone called from the Jewish Agency and said they found a place for me at some program for young people: I should prepare my documents for departure. To the last moment I wasn't sure whether to go or not. My mother told me to leave since I going nowhere with my heroin and alcohol use. She began to draw a fabulous picture of my future life in Israel—a new country, new friends, no drug use, no alcohol use, and everything was going to be ok. In the end she talked me into. I really didn't know anything

about the country … Little was explained to me by the recruiting agency except for what documents were needed for immigration.

On leaving Russia I told my friends that I would not survive in Israel more than a year so they should not forget me. I got so drunk on the plane going there that I don't remember what happened in the airport. I was sent to a youth program and then to an absorption center in the southern region of the country. I began to learn Hebrew, studied for 2 months and kept on with vodka even though I was told drug and alcohol use was forbidden and a reason for expulsion from the "Ulpan" program. In the end the fairy tale about Israel led me to quite a shock going from a life in St. Petersburg to restrictive conditions in a desert environment. I adjusted quickly enough and visited Beer Sheva with other immigrants a couple times a week. There we bought vodka and under a sweater or in any other way sneaked it to our center. Once a week, after receiving the Sabbath, we would drink intensively. I even had a bottle of vodka in my closet; I would take a drink from it during the day. Of course after that I had to bypass every "Madrich" so he would not notice or smell anything.

After 2 months in the absorption program, I met Dany who visited the program saying he owned a coffee shop. He offered immigrant girls work; easy with good wages. What did I know about this "coffee shop"? I agreed. I was the only one and drove away with him to see my future workplace. We spoke to each other in very basic English.

I soon learned it wasn't a coffee shop when I entered the place. Back then I wasn't an innocent girl, but thought I would be working in a regular "sex shop" as a saleswoman. I couldn't even imagine that the situation was worse and that an immigrant in Israel could be tricked this way. I am not saying that in Russia everything was perfect. There I was also tricked but I understood in what way and for what. But the fact is it happened here in Israel. For me it was a low blow. I just wasn't ready for this kind of thing. When I realized where I was, I immediately wanted to go back to the absorption center. Dany calmed me down by saying it was too late to go back; I should spend the night at his place and return to the center in the morning. The next day I returned to find out I was expelled and no longer living there.

I think if I was visiting friends or relatives no one would have said anything. But they knew what kind of people came from Beer Sheva to invite girls to work at the "coffee shop." When I did not return back on time, everybody thought that I started to work. In addition they remembered all my sins connected to drinking. I think Dany knew that it would end this way and that's why he insisted I spend the night in the city.

Can you imagine my condition—alone in a strange country without knowing the local language, without any relatives, and without a place to sleep? I did not know what to do but I had Dany so I went with him to the: "Sex Shop," "Strip Club," "Mahon" as a striptease dancer only.

For almost a year I began to drink big time. I never imagined that I would end up this way. At the beginning I was scared and embarrassed. To overcome myself I drank a lot and don't remember myself being sober. My first thought when I woke up in the morning was whether I had enough vodka to get myself ready for work.

I forgot about drugs, it was all about alcohol. I wasn't paid much but Dany provided most things. He was making money off of me and only now do I realize that I could have made up to $3,000 a month.

After I saved some money I rented an apartment. I paid 3 months in advance. Then Dany suggested I live at his house but not with him. In one part of the house he and his wife lived and at the other, my room. I had a difficult relationship with Dany. When I was expelled from the absorption center, I realized that I didn't have a choice and I needed to work. I told Dany that I couldn't do it without vodka. He decided to monitor my alcohol use and buy my vodka. I remember getting drunk 1 day and taking off my clothes in front of him. I drank more and by morning realized we had sex that night. On the Sabbath, we didn't work but he would get me drunk and take advantage of me. In his home if he had any problems with his wife, he knew that with a liter of vodka his night with me was guaranteed. After 6 months of this he kicked me out and deducted the cost of living at his place from my money. Again, I was helpless.

After this experience, I decided to go to back to Russia for a short visit. There, my mother had remarried again. It was the fifth time. I had an additional stepfather—Misha, another Jew and a drunk. I told my mother that the main reason for my return was to get alcohol treatment. After a week in Saint Petersburg, she began reminding me why I came in the first place. We went to a narcologist and he prescribed me a medicine—"Espiral"—a medical preparation used for the treatment of alcoholism. I took it for a while but then I met my old buddies who never stopped injecting. After a break for almost a year, I began to use heroin again with them.

When my mother saw what was happening to me she said that I needed to go back to Israel. There I just drank and here I started to use drugs again. I had no choice so I returned to Israel and back to Dany. I lived at his place for a week and thanks to him I met his brother Asher. He also owned "sex shop," "peep show," and "mahon" all under the same roof. Then I started to work at his place. After I returned to Israel I began to drink again. All that mattered for Asher was that I could stand on my feet and perform my striptease number. I was in such a condition that I didn't care about money. Everything that was to do with money was handled by Asher; he talked to the clients and all the money went to him. Vodka was important for me and a lot of it. I was sleeping at the workplace.

Since no one was controlling me, I drank enormous amounts when I returned from Russia and when I worked for Asher. I remember fragments of my life then, walking in the street, drunk, and constantly falling. I would get up, walk some steps, and fall again. Eventually, I found myself at Soroka Hospital because I had terrible abdominal pain; I do not remember how I got there but a couple of hours later I ran out of there going from pub to pub for a drink.

On one evening I met an Arab; he invited me for a drink at his place and promised he would not touch me but there he beat me badly and raped me. After that I remember being in the hospital again; how I got there I do not know. They were treating my wounds and asking me who did this to me. So I told them Asher did it. I received treatment and returned to my workplace to spend the night only to find the place was closed for 3 days. I didn't know where Asher lived and I had no place

to go. I spent 3 days on the streets. I was lucky that it was summer at that time. Afterwards I found out that he was arrested for rape and beating; he had to spend the day in jail until they figured out it was not him.

When we met I asked for his forgiveness in every way I knew. But he could not understand how I could have done such a thing—to tell such a lie. I didn't understand either, I was drunk. He didn't forgive me and kicked me out. I spent a couple of days on the streets, I don't remember from where I got the money for alcohol and food. I had to go somewhere so I decided to go to Dany, his brother. I told him everything and that I was in no condition to work; he saw my terrible bruises. If I was able to do something it was to drink vodka.

Dany let me stay at his place. He locked me up during the day at the "mahon." I was without a drink for almost 12 h; I was shaking and shivering so Dany called for an ambulance and I was taken to Soroka Hospital again. There I had my first epileptic seizure. I lost all control over my body; I was thrown from side to side, bent, and twisted to arches. They immediately gave me an injection of medication and brought me to a patient ward where I spent a couple of days. In the hospital I had a couple of more seizures but they were weaker and I began to realize that I could not keep drinking the way I do. After Soroka, I began to work for Dany, again for pennies. I didn't quit drinking but I tried not to get drunk till unconsciousness because Dany, as before, had me under his control. But even that proved not to be enough when I was offered local heroin by some of the clients. I was now sniffing and smoking … forgetting about alcohol. My salvation was heroin, not alcohol. In spite of it all, I was going back and forth using heroin and alcohol, binge drinking for 5–6 days, then going back to smoking heroin. I had a double dependence—when I used heroin I didn't want to drink; when I was drinking alcohol I didn't crave heroin. During the first 2 and half years in Israel I was half of the time drunk and the other half high from heroin. I used cocaine but only a few times.

After I finished with Dany I returned to Asher as a prostitute to earn enough money for heroin—5 or 6 "manot" every day. Before then I worked only as a striptease dancer. Asher did not have a lot of clients so we focused on quality and not quantity. I had regular clients. On several occasions they invited me to their home. I was not greedy for money. If I came across a client that would pay additional money for some special service, I preferred to turn the offer down. I could have earned more money this way but I just didn't need to and I was concerned about my health.

After my time in Russia and return to Israel my mother came to visit me a couple of times. She would come and see what was going on with me, cry, and leave. Then she and my stepfather immigrated; rather my stepfather did and my mother came as a tourist because she was denied a visa. With my mother in Israel, life became easier for me; she insisted that I quit my job and move in with them. I received government disability support and for the first time in years began to take care of my health—cirrhosis of the liver at a very serious stage.

Life with my stepfather in Israel was bad from the start. I told my mother right away: "Mother, he is shit." We fought regularly except when I drank with him. My mother also has a hard time with him but she tried to hold on because she didn't

have Israeli citizenship. He could say all sorts of stuff and my mother would be deported from the country. He didn't like living in Israel and began to drink more often; we were forced to live together. He couldn't leave—he didn't have the money to go back to Russia; mother was trapped with him because she didn't have citizenship. Both worked in menial laundry and cleaning-related jobs. I also couldn't leave because my path out was only with Dany or Asher.

I have continued to live with my mother and step father but I took methadone for treatment. I didn't use heroin and occasionally I had a drink. I smoked "grass" very often. It's not heroin or vodka and you got to have something for the soul. All my plans were now linked to my health. I totally ruined my liver and needed to start treatment with interferon. If the treatment helped I can talk about the future. If not, in 5 years I was going to be dead. With this kind of diagnosis you don't live long. Also, I planned to keep going with methadone.

Epilogue. Nika was able to stop the use of methadone and alcohol when she decided to have healthy children. She passed through successful treatment of liver cirrhosis, continued to smoke marijuana, and had two children out of marriage from two different men. After stopping heroin and alcohol use and the birth of two children, she voluntarily entered an outpatient psychiatric treatment program to address unresolved issues related to the events she experienced. Nika took antidepressants on a regular basis and did not work, but lived with her children and mother who received Israeli citizenship. Her Jewish stepfather returned to Russia and her mother's apartment in Saint Petersburg was rented serving as an additional source of income.

The case of Nika is one of many women who, in search of a new life in Israel, find themselves trapped in conditions of being used, abused, and discarded. Her story, linked to many drug abuse causal factors discussed at the beginning of this chapter (e.g., relations with family and friends, living conditions, school problems, and exploitation), is sadly common in many countries throughout the world.

3.3.4 Males

3.3.4.1 Heroin Use in Perspective

The value of the global opiate market is estimated at US$ 65 billion per year. Afghanistan alone accounts for more than 90 % of global opium production. Every year, the equivalent of some 3,500 tons of opium flows from Afghanistan to the rest of the world through its neighboring countries: 40 % through the Islamic Republic of Iran, 30 % through Pakistan, and the rest through Central Asia (Tajikistan, Uzbekistan, and Turkmenistan). The potential gross export value of Afghanistan's opiates was $2.8 billion in 2009—the equivalent of about a quarter of the country's gross domestic product (GDP) (UNODC, 2009).

Thomas Schweich (2008), who served the Bush administration as the ambassador for counternarcotics and justice reform in Afghanistan, provides a revealing expose

of conditions in Afghanistan. The following excerpt is drawn from his article published in the New York Times Magazine (Schweich, 2008):

> I took to heart Karzai's (Afghan President) strong statements against the Afghan drug trade. That was my first mistake…Over the next two years I would discover how deeply the Afghan government was involved in protecting the opium trade—by shielding it from American-designed policies…The trouble is that the fighting is unlikely to end as long as the Taliban can finance themselves through drugs—and as long as the Kabul government is dependent on opium to sustain its own hold on power…[T]he Afghans congratulated themselves on their tremendous success in fighting drugs even as everyone knew the problem was worse than ever…Less than 1 percent of the opium produced in Afghanistan was being seized there. There was no coherent strategy to resolve these issues among the U.S. agencies and the Afghan government…despite some successes, poppy cultivation over all would grow by about 17 percent in 2007. Opium cultivation in Afghanistan is no longer associated with poverty—quite the opposite.

The United Nations estimates that in 2010 between 153 and 300 million people aged 15–64 (about 5 % of the world's population for that age group) had used an illicit substance at least once in the previous year (UNODC, 2012). By far, the most common substance used is cannabis (i.e. marijuana or hashish) compared to opioid use (mainly heroin, morphine, and nonmedical use of prescription opioids) that is used by about 0.7 % of the population. In terms of harm to health including the spread of infectious disease such as Hepatitis C and HIV/AIDS, opioids (particularly heroin) are reported as the main type of drug that is injected and as a major cause of drug-related deaths. For this reason, opiates are the main problem drug throughout the world—about 16.5 million people use opium, heroin, and morphine annually. Those who use and abuse opiates make up about two-thirds to three quarters of the people in need of treatment. About 4 million, or 22 %, of users are in Europe, mainly the central and eastern subregions (e.g., the Russian Federation and the Ukraine), where about 1.2–1.3 % of the population aged 15–64 years have used opiates at least once in the previous year. Presently, Russia is the largest single market for Afghan-origin heroin. There are 2.5 million drug addicts and over 5.1 million drug users, and HIV infection rates are up to 61 % among drug users in some regions of the country. Officials estimate that there are 80,000 new drug users each year; more than 30,000 people die annually of drug overdoses and another 70,000 deaths per year are drug-related in Russia (RIA Novosti, 2012; UNODC, 2011).

It is widely acknowledged that the spread of HIV/AIDS as well as hepatitis B and C and other blood-borne viruses is linked, in part, to injecting drugs—mostly heroin. Eastern Europe and Central Asia is the only region where HIV prevalence clearly remains on the rise; HIV has almost tripled since 2000 and reached an estimated 1.4 million people in 2009. The epidemic in the region is concentrated mainly among drug users, sex workers and their sexual partners, and, to a much lesser extent, men who have sex with men (UNODC, 2011).

Among infectious diseases, after HIV/AIDS, tuberculosis (TB) is the second leading killer in the world. HIV and TB are closely linked and up to 50 % of those people living with HIV can expect to develop TB. About 2 billion people are thought to be infected with TB and about 1.3 million die from the disease each year (Mohajan, 2014). TB is most prevalent in crowded low-income areas with substandard health

conditions, and it is linked to drug users and alcoholics who have a history of crime, imprisonment, and unemployment (Migliori & Ambrosetti, 1998). Drug users are two to six times more likely to contract TB than nonusers (NIDA, 1999). Reported TB rates for correctional system populations have been 10–100 times higher than rates for the local civilian populations, and TB outbreaks with a high number of TB multidrug-resistant cases have been documented. Prisons, heavily populated with drug offenders, are known as social and sanitary pathology reservoirs in which TB is often associated with chronic infectious diseases caused by HIV, hepatitis B virus (HBV), or hepatitis C virus (HCV). HCV prevalence among inmates is 30–40 %, which is higher than that in the general population and is related to injection drug use (CDC, 2012).

In the former Soviet Union, deteriorating conditions including poverty, unemployment, inadequate hygiene and heath care, a lack of preventive health education, and poorly ventilated prisons where inmates fall ill have provided fertile ground for the rise of injecting drug use, the spread of HIV, and tuberculosis referred to as "Ebola with wings" (Israelowitz, 2004; Malinowska-Sempruch, Hoover, & Alexandrova, 2003). Many of these drug users found their way to Israel in the 1990s claiming eligibility for citizenship (Israelowitz & Myers, 2011; UNODC, 2012).

3.3.4.2 Former Soviet Union Immigrants

"A person's cultural affiliation often determines the person's values and attitudes about health issues, responses to messages, and even the use of alcohol, tobacco and other drugs" (Wright, 1994, p. 1). From 1989 to 1998, the Israeli population of 4.5 million rose about 20 % primarily from the nearly one million Soviet immigrants, mostly from Russia and the Ukraine, who entered the country (Israelowitz & Reznik, 2013). A large proportion of the Russian-speaking immigrants had training and education in a variety of technical and professional fields; success was an important component of their worldview and culture (Philippov, 2010). However, there were immigrants who arrived in Israel with drug abuse problems and others became addicted during the absorption process (Israelowitz, Reznik, Spear, Brecht, & Rawson, 2007). Presently, Russian-speaking immigrants are 13 % of the Israel population but about 25 % of the heroin drug users in the country (Israelowitz et al., 2007).

3.3.4.3 Heroin-Using Immigrants from Russia, Ukraine, and the Caucasus Region

Most studies of FSU immigrants have aggregated data that fails to capture racial/ethnic differences that may exist within the broad FSU population. This issue is becoming increasingly important to policy and treatment (SAMHSA, 2007). In response, the RADAR Center, Ben-Gurion University, compared drug use patterns and severity among male immigrants from Russia, the Ukraine, and the Caucasus mountain region (Kavkaz people) residing in Israel and profiled their psychosocial

needs. Such information has contributed to developing clinical interventions to effectively treat drug abuse disorders. Among the key findings from Israelowitz & Reznik, 2014 and Israelowitz, Reznik, Rawson, & Hasson, 2009 are here:

- Kavkaz drug users were significantly older, have less education, higher unemployment, and more Jewish religion identity than those from the Russia or the Ukraine.
- Kavkaz males have a longer history of drug use likely attributed to their older age.
- Kavkaz males report a higher percentage of last 30-day cannabis and cocaine use.
- Ukrainian males report a higher percentage of lifetime opium users.
- All three groups (i.e. Russians, Ukrainians, and Kavkaz) have high levels of employment, legal, family/social, medical, and psychiatric problems.
- No significant differences between groups exist in terms of rates of chronic medical problems, hepatitis C, HIV/AIDS, and tuberculosis.

3.3.4.4 Heroin Use in Israel: A Comparison Between Israeli and FSU Immigrants

Expectations of severe health problems and high-risk drug behaviors abound for the FSU immigrant population in Israel. However, there was not any systematic study of such trends compared to the native Israeli population until 2006. Based on data collected by the RADAR Center, the following has been found:

- FSU drug users tend to be significantly younger than the native Israeli drug users.
- FSU and native Israeli addicts have similar educational backgrounds.
- FSU addicts are more likely to be employed.
- Identification with the Jewish religion is less common among the FSU addicts.
- Native Israeli addicts reveal more years of heroin use than those from the FSU.
- FSU addicts' lifetime opiate use, namely, opium, is more extensive than what the native Israelis report.
- FSU addicts report more lifetime alcohol, polydrug use, and cannabis use than their native-born counterparts (Israelowitz, Reznik, Spear, Brecht & Rawson 2007).

Gender Status Differences: *FSU Men and Women.* A comparison of FSU female and male drug users treatment shows (Israelowitz & Reznik, 2013):

- Females tend to be: younger, married, or living with a partner; not Jewish; less likely to have a criminal record resulting in a conviction, incarceration, and/or parole, and more sexually abused.
- Females report more chronic illness; however, their level of HIV/HCV/TB infection is similar to males.
- Patterns of heroin, alcohol, and other drug use are similar among females and males; cannabis use is higher among males and cocaine use higher among females.
- Females are more likely than males to prefer short-term detoxification (only) as a treatment intervention.
- Females have more employment-related problems than males.

3.4 Older Adults: Prescription Use

Benzodiazepines are a commonly prescribed psychotropic drug often used by elderly persons for anxiety and insomnia (Longo & Johnson, 2000). Epidemiology of benzodiazepines is controversial because prolonged use may lead to dependence (Gonzales, Stern, Emmerich, & Rauch, 1992). Risk factors associated with long-term use include increased age, female gender status, emotional distress, depression, poor health, memory impairment, and falls (Roberts et al., 1998). Inappropriate use of benzodiazepines among older people, like other psychotropic drugs including alcohol, is a major public health problem that leads to mortality, morbidity, and related health costs (Moos, Brennan, Schutte, & Moos, 2004). Studies have documented that the level of potentially inappropriate medication use among nursing home residents may be as much as 40 % and 14–37 % for elderly people in community-based care facilities (Fialová et al., 2005; Ma, Lum, Dai, Kwok, & Woo, 2007).

Little is known about psychotropic drug use among older Israeli adults including immigrants caught up in acculturation processes (Isralowitz, Reznik, & Borkin, 2006). Israel, a country built on the large waves of immigrants from multiple countries, now faces an increasing percentage of its population as older adults. Research shows older adults, especially women who tend to live longer, use harmful prescription drugs like benzodiazepines. Benzodiazepine use was reported by 69 %; among them 45 % use the drug on a daily basis (Isralowitz et al., 2006) for insomnia as well as stress and anxiety, sadness and loneliness, and adjustment difficulties.

Fialová et al. (2005) have noted that the possible abuse of psychotropic drugs among community-dwelling older adults appears to be a common problem with variations reflective of country-specific drug policies, care provisions, socioeconomic and health conditions, as well as other reasons. Large-scale immigration of older people with adjustment problems to a new environment in countries like Israel is another potential cause of inappropriate drug use. Statements among late-life women attributing daily benzodiazepine include: “It is difficult for me to get used to life in Israel. My husband died, my children visit very seldom … I do not know Hebrew and all day I sit at home and watch TV in Russian … bad news about events in Israel frightens me. I very strongly miss my former life in the Ukraine.” “I cannot adjust to life in Israel. My Hebrew (speaking) is bad and I must ask others to help me with translation … I was once helped by my children and husband. My husband died a few years ago and my children returned to Russia … I am in Israel absolutely alone … it is hard for me to continue life here and I feel like a foreigner.” “We came to Israel because we have many relatives here … my daughter and her husband are musicians, she now washes floors and he works as a simple laborer in a factory. Their financial situation is very bad with lots of debts. I hurt very much because I cannot help them” (Isralowitz et al., 2006, p. 679).

Service provider and client miscommunication, especially if it involves use of a foreign language, is another reason for possible improper drug use among elderly people. In a report on the prevention of drug abuse and misuse, Carlson (1994) points out that older adults often have sensory and cognitive deficits that make

understanding medication instructions difficult. Also, an older person may play a role in medication misuse by failing to report symptoms, underusing medications to avoid side effects or save money, or using them in combination with alcohol that heightens the risk of adverse effects.

Finally, it is important to point out that Russian-speaking elderly people in Israel are not a homogeneous population and there appears to be variability in biological, psychological, social, and illness factors that may influence inappropriate drug use (Israelowitz, Shpiegel, Reznik, Borkin, & Snir, 2009). Older women especially have health problems including those of a gynecological nature that are often neglected leading to opiate and benzodiazepine prescription drug treatment. This suggests that the management of age-related problems including improper psychotropic drug use will require specific tailoring of treatments and services to address quality of life needs of older adults (Israelowitz et al., 2006; Patterson, Lacro, & Jeste, 1999).

3.5 Discussion and Conclusion

Treatment of drug users is a difficult process and it has been noted by Sullivan and Fleming (1997) that researchers have not confirmed that separate programs for special populations such as Russian-speaking immigrants from the former Soviet Union are superior to mainstream efforts with respect to outcomes. Experts question the cost-effectiveness of such special programs and clinicians must be wary of defining any patient in relation only to age, gender, racial group membership, or functional characteristics. One study has found that effort focused on specific problem histories of drug users may not improve the long-term effectiveness of drug treatment or the lives of those who have been subject to such conditions (Fiorentine, Pilati, & Hillhouse, 1999). However, some experts believe treatment of special populations may be enhanced if their particular needs are considered and met (American Psychiatric Association, 1995; Institute of Medicine, 1990; Kauffman & Woody, 1995; Landry, 1996; Sullivan & Fleming, 1997). Such program activities should be part of a treatment environment that integrates all clients regardless of their personal attributes and background characteristics (e.g., country of origin and gender status).

3.6 Future Directions

It is clear that the interrelationships between male and female drug users with native-born/immigrant status are undoubtedly complex. The information presented here and from other research suggests that high-risk behaviors may cluster, and therefore detailed analyses are needed to delineate the nature of such interrelationships. Second, the interviews of the participants were collected at one point in time and from those receiving some form of ambulatory day care treatment for their

addiction; therefore, caution should be exercised in generalizing the results provided in this chapter.

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Chapter 4
Toward Uniform Data Collection and Monitoring of Israeli and Palestinian Adolescent Drug Use

Richard Isralowitz, Mohammed Afifi, and Alexander Reznik

4.1 Introduction

Nearly all drug use (e.g., marijuana/hashish, cocaine and crack, inhalants, hallucinogens, heroin, and prescription-type drugs used for nonmedical purposes) can be traced back to preadolescent and adolescent years. Generally, if a person has not begun to use drugs during this period, the chances are that he or she never will. Among those who do use, school problems are likely to occur as a result including low attendance rates, poor academic performance, dropping out, or expulsion. Other problems include delinquency, crime, risky sexual activities, and an escalation of more dangerous drug use. Drug use among youth is also related to higher death rates resulting from car accidents, suicide, homicide, and illness. Also, many mental health problems among youth, including depression, anxiety, paranoia, hallucinations, developmental lags, delusions, and mood disturbances, may be linked to drug use (Isralowitz & Myers, 2011).

R. Isralowitz (✉)
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel
e-mail: richard@bgu.ac.il

A. Reznik
Senior Research Associate, Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben Gurion University, Beer Sheva, Israel

M. Afifi
Substance Abuse Research Center, Palestine

R. Isralowitz, P.A. Findley (eds.), *Mental Health and Addiction Care in the Middle East*, Advances in Mental Health and Addiction,
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4.2 Information Collection in the Middle East

To monitor drug use patterns over time and across locations among youth in the Middle East, a culturally sensitive instrument needed to be developed—one that was simply worded and not time consuming for youth at high risk including those who dropped out of school. The development of such an instrument occurred in three main phases: (1) collection of existing surveys; (2) contact with relevant health professionals in the United States, in Europe, and in the region; and (3) assessment of prevention and treatment priorities among service providers addressing adolescent drug abuse and addiction problems. Issues for the development of the Substance Use Survey Instrument (SUSI)[1] were refined through consultation with experts and adolescents with support received from the United States Agency for International Development—Middle East Regional Cooperation Program (Israelowitz, Sussman, Afifi, Rawson, Babor & Monteiro, 2001). During the last 15 years, this valid and reliable instrument has been modified and updated numerous times to address new substances and to simplify the questions asked because of the limited reading comprehension of the target population. Although the instrument is primarily for use with high-risk youth, including those who dropped out of school, the nature of the instrument has been modified for use with other groups including young adults and adults (Israelowitz & Reznik, 2015); Israelowitz, Reznik & Pruginin, 2015).

4.2.1 Instrument Development

Assessment and monitoring of drug use attitudes and behavior have been an ongoing concern for Israeli and Palestinian people (Israelowitz et al., 2001). As noted in the introductory chapter to this book, this common concern served as a focal point for promoting communication, cooperation, and coordination of efforts, at least, in respect to each group's own concerns (Israelowitz & Findley, 2016). Training, resource sharing, needs assessment, and research were among the activities generated to monitor patterns of drug use and related problem behavior. However, reflecting back on the joint efforts promoted, the development of the joint data collection instrument was an important, if not the most important, undertaking to address issues of mutual concern to Israeli and Palestinian people.

Many instruments have been developed to assess the health of young people (e.g., Miech, Johnston, O'Malley, Bachman, & Schulenberg, 2015); and nationwide health surveys exist in countries such as in the United States (e.g., the National Institute on Drug Abuse—Monitoring the Future (MTF), Substance Abuse Mental

[1] The Substance Use Survey Instrument (SUSI) may be obtained from the Ben-Gurion University Regional Alcohol and Drug Abuse Research (RADAR) Center by contacting Professor Richard Israelowitz at richard@bgu.ac.il. The SUSI is available in English, Hebrew, and Arabic.

Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC) and in European countries (e.g., EMCDDA—European Monitoring Centre for Drugs and Drug Addiction).

In 1988, under the authority of the "Israel Anti-Drug Authority Law," the Israel Anti-Drug Authority (IADA) was created. The IADA developed and then launched a survey of public school youth to survey individuals once every 4 years with a 250-item questionnaire. However, this survey has not been conducted since 2009 because of multiple issues including alleged corruption that have affected the nature and scope of IADA efforts (Efrati, 2015). The IADA survey included questions about patterns of drug use, attitudes, and behavioral intentions taken from, for the most part, Monitoring the Future (Johnston, O'Malley, Bachman, & Schulenberg, 2009) and the National Survey on Drug Use and Health (SAMHSA, 2009) surveys in the United States (Neumark & Bar-Hamburger, 2011). These surveys are described below.

4.3 Key Data Collection Instruments: Making the Complex Simple

4.3.1 National Institute on Drug Abuse: Monitoring the Future (MTF)

This annual survey includes information about the drug, alcohol, and cigarette use patterns and related attitudes and beliefs among American secondary school students, college students, and young adults. Each year, a total of approximately 50,000 8th, 10th, and 12th grade students are surveyed (12th graders since 1975 and 8th and 10th graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation. The Monitoring the Future (MTF) study is funded by the National Institute on Drug Abuse, a part of the National Institutes of Health. MTF is conducted at the Survey Research Center in the Institute for Social Research at the University of Michigan. Information about the survey and results are available at http://monitoringthefuture.org and https://nsduhweb.rti.org/respweb/project_description.html (University of Michigan, 2015; NIDA, 2013).

4.3.2 Centers for Disease Control and Prevention (CDC): Youth Risk Behavior Surveillance System (YRBSS)

The Youth Risk Behavior Surveillance System (YRBSS), developed in 1990, monitors priority health-risk behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. Specifically, these behaviors are related to unintentional injuries and violence, unintended

pregnancy and sexually transmitted disease including HIV infection, alcohol and other drug use, tobacco use, unhealthy dietary behaviors, and inadequate physical activity (CDC, 2015c). The YRBSS includes a national school-based survey conducted by CDC. Forty-seven state surveys, six territory surveys, two tribal government surveys, and 22 local surveys are conducted among students in grades 9–12. YRBSS monitors six categories of priority health-risk behaviors among youth and young adults, including (1) behaviors that contribute to unintentional injuries and violence; (2) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; (3) alcohol and other drug use; (4) tobacco use; (5) unhealthy dietary behaviors; and (6) inadequate physical activity. Also, YRBSS monitors the prevalence of obesity and asthma. YRBSS data are used to measure progress toward achieving national health objectives for *Healthy People 2020* and other program and policy indicators, assess trends in priority health-risk behaviors among high school students, and evaluate the impact of broad school and community interventions at the national, state, and local levels (CDC, 2011). Information about the survey is available at http://www.cdc.gov/healthyyouth/data/yrbs/index.htm (CDC, 2015a, 2015b; YRBSS, 2015).

4.3.3 US Substance Abuse Mental Health Services Administration (SAMHSA): National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency of the US Public Health Service in the US Department of Health and Human Services (DHHS). Data from the NSDUH provide national- and state-level estimates on the use of tobacco, alcohol, and illicit drugs including nonmedical use of prescription drugs and mental health in the United States. To assess and monitor the nature of drug and alcohol use and the consequences of abuse, NSDUH (1) provides accurate data on the level and patterns of alcohol, tobacco, and illegal substance use and abuse; (2) tracks trends in the use of alcohol, tobacco, and various types of drugs; (3) assesses the consequences of substance use and abuse; and (4) identifies those groups at high risk for substance use and abuse. Many government agencies, private organizations, individual researchers, and the public use NSDUH data. Other federal, state, and local agencies, such as the White House Office of National Drug Control Policy and the US Department of Justice, use the information to support prevention programs and monitor drug control strategies. Information about NSDUH is available at https://nsduhweb.rti.org/respweb/homepage.cfm (NSDUH, 2015).

4.3.4 World Health Organization (WHO) Global School-Based Student Health Survey (GSHS)

According to the World Health Organization, the Global School-Based Student Health Survey (GSHS) is:

> a collaborative surveillance project designed to help countries measure and assess the behavioral risk factors and protective factors in key areas among young people aged 13 to 17 years (WHO, 2015b). The GSHS is a relatively low-cost school-based survey that uses a self-administered questionnaire to obtain data on young people's health behavior and protective factors related to the leading causes of disease and death among children and adults worldwide. (WHO, 2016)

Among the key areas are alcohol use, dietary behaviors, drug use, hygiene, mental health, physical activity, protective factors, sexual behaviors, tobacco use, and violence and unintentional injury. When used for Moslem countries, alcohol use and sexual behaviors are not reported. Information about GSHS is available at http://www.who.int/chp/gshs/en/ (GSHS, 2010; WHO, 2015a, 2015b, 2015c).[2]

4.3.5 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Statistics show that around one in three young Europeans has tried an illicit drug and at least one European Union (EU) citizen dies every hour from a drug overdose. At the same time, ever-changing patterns in supply and demand call for constant monitoring and dynamic responses. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was established in 1993. The EMCDDA provides the EU and its member states with an overview of European drug problems. Also, it offers policymakers, professionals, and practitioners with data needed for informed drug laws, intervention strategies, and research. It includes lifetime, last year, and last month prevalence of drug use by age, gender, and country including all adults (aged 15–64), young adults (aged 15–34), and youth (aged 15–24). In sum, the EMCDDA reports on issues of drug market dynamics in Europe—global and local differences, drug supply and the market, drug use and drug-related problems, and health and social responses to drug problems. It is the reference point for drugs and drug addiction information in Europe. EMCDDA is available at http://www.emcdda.europa.eu/ (EMCDDA, 2012; 2015a, 2015b).

[2] WHO (2015a) data available/reported for Israel is excluded from the Eastern Mediterranean Region.

4.4 Toward Uniform Drug Use Data Collection Among High-Risk Youth in the Middle East: Substance Use Survey Instrument (SUSI)

This instrument was initially developed as a means of collecting data among high-risk youth. It consists of 31 questions about personal background characteristics, substance use patterns, and related problem behavior. Many of the SUSI questions are similar to those used for the US National Institute on Drug Abuse (NIDA) Monitoring the Future—Adolescent Drug Use Survey and the Substance Abuse and Mental Health Services Administration National Survey on Drug Use and Health mentioned above. The instrument was developed with grant support from the United States Agency for International Development—Middle East Regional Cooperation Program and input from experts affiliated with universities, government agencies, and regional nonprofit organizations in the United States and the World Health Organization, office based in Geneva, Switzerland. Prepared in English, the questionnaire was translated to Hebrew and Arabic then back translated. Since 1998, the instrument has been modified more than 30 times to collect up-to-date information about current drug use patterns and problem behavior. The questionnaire has been examined for construct validity purposes by the Integrated Substance Abuse Programs, University of California, Los Angeles (Reiber, 2002), as well as regional providers of prevention and treatment services for high-risk youth. The instrument is reliable (Cronbach Alpha, 0.93).

An adult version of the instrument (SUSI Adult) has been developed as well. This modified version consists of 58 questions. In addition to drug use patterns, SUSI Adult collects information about marital status; legal status; infectious diseases including HIV, HCV, and tuberculosis; family (parents') drug use; immigration status (when, where, etc.); and other details. This version of the instrument is reliable as well.

4.5 Conclusions and Future Directions

This chapter briefly discusses a process of instrument and data collection. Discussion is given to a process that served as a means of bringing two groups of people, Israeli and Palestinian, together to address a mutual concern—drug use among youth. The critical issue that remains from this effort is simple—follow-up over time and across locations to monitor and respond to drug-related issues including patterns of use among high-risk youth, particularly those who have dropped out of school.

The development of a simple and short data collection is a priority for obtaining useful information. The task is not to overload; the challenge is to make the instrument simple, short, and easily understood. Furthermore, it is important to know what information is needed and what information is of little value.

The goal of the Ben Gurion University RADAR Center has been to generate "usable knowledge" for understanding youth and adults at risk needs and improving service provision through relevant prevention and treatment training for personnel. Routinizing data collection and collecting data at the same place over time contributes to an understanding of needs for targeting interventions for modification of service provision.

Appendix 4.1: Substance Use Survey Instrument (SUSI-Israeli Version)

Please answer each question the best you can. Each question needs to be answered.

1. **Are you** (**mark one**)?

   _____Male
   _____Female

2. **What is your age**? _____years
3. **Are you** (**check one**)?

   ( ) Not religious
   ( ) Somewhat religious
   ( ) Religious
   ( ) Very religious

4. **Where was your mother born** (**check one**)?

   ( ) Israel
   ( ) Russia, Ukraine, or other than the former Soviet Union country
   ( ) Middle East country (other than Israel such as Morocco, etc.)
   ( ) Egypt, Jordan, Morocco, etc.
   ( ) Ethiopia
   ( ) European country (other than the former Soviet Union)
   ( ) Others (please write in your response): _____

5. **Who do you live with** (**check one**)?

   ( ) Both parents (or stepparents)
   ( ) Only with my mother (or stepmother)
   ( ) Only with my father (or stepfather)
   ( ) Sometimes with my mother (or stepmother) and sometimes with my father (or stepfather)
   ( ) Other persons
   ( ) Alone

6. **What is your work status**?

   ( ) Do not work
   ( ) Part-time job
   ( ) Full-time job

7. **Is someone in your family in contact with welfare services**?

   ( ) Yes ( ) No

8. **During the day, where do you spend most of your time (check one)**?

   ( ) School
   ( ) Work
   ( ) School/work combination
   ( ) Hanging around
   ( ) Home (your home or that of friends)
   ( ) Others (please indicate) _____

9. **In the evening/night (not on holidays), where do you spend most of your time (check one)**?

   ( ) Work
   ( ) Hanging around in the streets, malls, playgrounds, parks, etc.
   ( ) Home (your home or that of friends)
   ( ) Cafes, pubs, etc.
   ( ) Others (please indicate) _____

10. **Are you enrolled in school**?

    ( ) Yes (if yes, please answer questions 11, 12, and 13)
    ( ) No (if no, please skip to question 14)

11. **What is your grade level in school**? _____
12. **During the last month, did you miss school**?

    ( ) Yes ( ) No

13. **During the last month, were you late for school**?

    ( ) Yes ( ) No

14. **During your life, have you used the following substances**? **Also, please indicate your age when you first used the substance (circle the best answer for each substance and fill in your age when you first used the substance).**

	Used		**Age—first used**
Cigarettes (and other tobacco products)	**Yes**	**No**	_____ **yrs.**
Beer	**Yes**	**No**	_____ **yrs.**
Wine (other than for religious purposes)	**Yes**	**No**	_____ **yrs.**
Hard liquor (e.g., vodka, whiskey)	**Yes**	**No**	_____ **yrs.**
Marijuana	**Yes**	**No**	_____ **yrs.**

Hashish	**Yes**	**No**	_____ **yrs.**
Ecstasy	**Yes**	**No**	_____ **yrs.**
Stimulants/amphetamines (e.g., speed)	**Yes**	**No**	_____ **yrs.**
LSD			
Energy drinks (e.g., Red Bull)	**Yes**	**No**	_____ **yrs.**
Mix energy drinks and alcohol	**Yes**	**No**	_____ **yrs.**
Inhalants	**Yes**	**No**	_____ **yrs.**
Glue	**Yes**	**No**	_____ **yrs.**
Aerosols (e.g., hairspray, air fresheners)	**Yes**	**No**	_____ **yrs.**
Solvents (e.g., nail polish, paint thinner, etc.)	**Yes**	**No**	_____ **yrs.**
Gases (e.g., gasoline)	**Yes**	**No**	_____ **yrs.**
Cleaninng fluids (spot remover, etc.)	**Yes**	**No**	_____ **yrs.**
Food products (vegetable cooking sprays)	**Yes**	**No**	_____ **yrs.**
Other gases (e.g., butane, air conditioner gas)	**Yes**	**No**	_____ **yrs.**
Other inhalants	**Yes**	**No**	_____ **yrs.**
Prescription drugs	**Yes**	**No**	_____ **yrs.**
Pain relievers (e.g., OxyContin, codeine, etc.)	**Yes**	**No**	_____ **yrs.**
Sedatives/tranquilizers (e.g., Clonex, Clonazepam, etc.)	**Yes**	**No**	_____ **yrs.**
Other prescription drugs	**Yes**	**No**	_____ **yrs.**
Other illegal drugs (please fill in the substance) _____	**Yes**	**No**	_____ **yrs.**
Legal over-the-counter drugs (please fill in the substance) _____	**Yes**	**No**	_____ **yrs.**
Legal designer/synthetic drugs (drugs of "pitzutziot," e.g., "hagigat")	**Yes**	**No**	_____ **yrs.**

15. **During the <u>last month,</u> have you used the following substances** (**circle the best answer for each substance**)?

	Used	
Cigarettes (and other tobacco products)	**Yes**	**No**
Beer	**Yes**	**No**
Wine (other than for religious purposes)	**Yes**	**No**
Hard liquor (e.g., vodka, whiskey)	**Yes**	**No**
Marijuana	**Yes**	**No**
Hashish	**Yes**	**No**
Ecstasy	**Yes**	**No**
Stimulants/amphetamines (e.g., speed)	**Yes**	**No**
LSD	**Yes**	**No**
Energy drinks (e.g., Red Bull)	**Yes**	**No**
Mix energy drinks and alcohol	**Yes**	**No**
Inhalants		
Glue	**Yes**	**No**
Aerosols (e.g., hairspray, air fresheners)	**Yes**	**No**
Solvents (e.g., nail polish, paint thinner, etc.)	**Yes**	**No**
Gases (e.g., gasoline)	**Yes**	**No**

Cleaning fluids (spot remover, etc.)	**Yes**	**No**
Food products (vegetable cooking sprays)	**Yes**	**No**
Other gases (e.g., butane, air conditioner gas)	**Yes**	**No**
Other inhalants	**Yes**	**No**
Prescription drugs		
Pain relievers (e.g., OxyContin, codeine, etc.)	**Yes**	**No**
Sedatives/tranquilizers (e.g., Clonex, etc.)	**Yes**	**No**
Other prescription drugs	**Yes**	**No**
Other illegal drugs (please fill in the substance) _____	**Yes**	**No**
Legal (**over the counter drugs**—please fill in the substance) _____	**Yes**	**No**
Legal designer/synthetic drugs (drugs of "pitzutziot," e.g., "hagigat")	**Yes**	**No**

16. **During <u>the last month</u>, have you had five or more alcohol beverages in one drinking occasion** (**circle the best answer**)?

    Yes **No**

17. **During <u>the last month</u>, have you been a passenger in a car when the driver had been drinking** (**circle the best answer**)?

    Yes **No**

18. **During <u>the last month</u>, have you been driving a car or motorcycle after drinking** (**circle the best answer**)?

    Yes **No**

19. **During <u>the past 12 months</u>, have you** (**circle the best answer**):

Gotten into a serious fight?	**Yes**	**No**
Carried a weapon?	**Yes**	**No**
Sold illegal drugs	**Yes**	**No**
Stolen or tried to steal	**Yes**	**No**

20. **During the past 12 months, has there been a decline in the following** (**circle the best answer**):

School achievement	**Yes**	**No**
Relations with family members	**Yes**	**No**
Relations with friends	**Yes**	**No**

21. **During <u>the past 12 months</u>, has any of the following <u>happened to you</u>** (**circle the best answer**)?

Something stolen	**Yes**	**No**
Someone damaged your property (e.g., clothes, bag, bicycle, etc.)	**Yes**	**No**

Someone threatened you with a weapon (e.g., gun, knife, etc.)	**Yes**	**No**
Someone threatened you without a weapon	**Yes**	**No**
Someone injured you with a weapon	**Yes**	**No**
Someone injured you without a weapon	**Yes**	**No**

22. **If you wanted to buy, would it be easy for you to get each of the following drugs (circle the best answer)?**

Cigarettes (and other tobacco products)	**Yes**	**No**
Alcohol including beer, wine, vodka, etc.	**Yes**	**No**
Marijuana	**Yes**	**No**
Hashish	**Yes**	**No**
Ecstasy	**Yes**	**No**
Inhalants (e.g., glue, paint remover, tippex, etc.)	**Yes**	**No**
Prescription drugs (e.g., pain relievers, sedatives, tranquilizers, etc.)	**Yes**	**No**
Stimulants/amphetamines (e.g., speed)	**Yes**	**No**
LSD	**Yes**	**No**
Other illegal drugs (please fill in the substance) _____	**Yes**	**No**
Legal designer/synthetic drugs (drugs of "pitzutziot" drugs, e.g., "hagigat")	**Yes**	**No**

Thank you for your cooperation.

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Chapter 5
A Parenting and Self-Care Intervention for Substance-Using Mothers: Promoting Resilience Among Israeli and Palestinian People

Debra A. Murphy

5.1 Introduction

As of 2013, 35 million people were living with HIV globally (World Health Organization, 2015). The National Institute of Health has called for interventions to address myriad of needs that exist within different groups of infected individuals. Chronically ill HIV-positive mothers express anxiety about being less able to meet their children's needs and feel unprepared in terms of parenting (AIDS.gov, 2015). Also, they report significantly higher levels of parenting stress (Anderson, 2008) compared to those with greater involvement with their children and better family cohesion. Overall, studies specific to HIV+ women demonstrate that they have elevated levels of stress and anxiety, which in turn are associated with fewer active coping strategies (Catz, Gore-Felton, & McClure, 2002). Mothers living with HIV (MLH) report their greatest source of stress is combining their maternal role with the psychological and medical demands of coping with a chronic, life-threatening condition and are more depressed and stressed than women without children (Tompkins, Henker, Whalen, Axelrod, & Comer, 1999).

Research of parental illness and child outcomes is in its early stage (Russell & Rauch, 2012). Prior to studies on parental HIV, most research focused on children affected by parental cancer. In a review of 15 years of literature on children of ill parents by Romer, Barkmann, Schulte-Markwort, Thomalla, and Riedesser (2002), it was reported that overall such had higher scores than controls on psychiatric symptom scales, with a tendency toward internalizing symptomatology. MLH report compromised parenting skills across a variety of parenting domains. Moreover, several studies have demonstrated that parental HIV is associated with

D.A. Murphy (✉)
Department of Psychiatry, Integrated Substance Abuse Programs, University of California at Los Angeles, Los Angeles, CA, USA
e-mail: dmurphy@mednet.ucla.edu

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negative outcomes for children (e.g., Bauman, Camacho, Silver, Hudis, & Draimin, 2002; Murphy & Marelich, 2008; Murphy, Marelich, Herbeck, & Payne, 2009; Reyland, McMahon, Higgins-Delessandro, & Luthar, 2002). These negative outcomes do not result from children's knowledge about maternal serostatus (Forehand et al., 1998) but are associated with compromised parenting. For example, MLH report lower levels of parenting self-efficacy than uninfected women (Dorsey, Klein, Forehand, & Family Health Project Research Group, 1999), less parental monitoring, and poorer mother–child relationships (Kotchick et al., 1997). In addition, HIV-positive mothers are more depressed and stressed than positive women without children (Tompkins et al., 1999). MLH who have little confidence they can enact parenting skills and limited knowledge of basic parenting practices are less likely to provide family routines consistently, monitor their children, or engender family cohesion or a close parent–child relationship, and such parenting skills were found to be associated with child functioning (Murphy, Armistead, Marelich, & Herbeck, 2015).

5.2 Parenting Skills Among HIV Parents

Do children of HIV-infected mothers experience higher rates of psychosocial maladjustment than children of non-HIV-infected mothers?

As Bauman, Silver, Draimin, and Hudis (2007) have noted, changes in the HIV epidemic have resulted in important social and psychological implications for children with a MLH: (1) survival time of women with HIV has increased; thus, children will spend more of their formative developmental years with an HIV-positive mother; (2) the majority of HIV+ women are of childbearing age, and they acquired HIV through heterosexual intercourse, meaning that their new pregnancies increase the number of children cared for by an HIV+ woman; and (3) the epidemic is spreading at a faster rate among women than men. In a US national probability study, it was determined that women are more likely than men to have children (46 % vs. 18 %) and to live with them (76 % vs. 23 %; Bogart et al., 2009; Cowgill et al., 2007), and children affected by parental HIV/AIDS face greater challenges to their psychosocial well-being compared to other children of the same age (e.g., Foster, 2006; Richter, Foster, & Sherr, 2006).

For children affected by maternal HIV who are aware of their MLH's HIV/AIDS status, approximately half experience significant distress (Armistead, Tannenbaum, Forehand, Morse, & Morse, 2001; Murphy, Roberts, & Hoffman, 2006). For some children this may remit over time. However, for a small group of children, the anxiety becomes maladaptive, resulting in behaviors such as acting out, trouble at school, and regressive behaviors such as wanting to sleep with an adult all the time

after a long period of having slept on their own or starting to wet the bed again (Murphy et al., 2006). According to Krauss, Letteney, De Baets, Baggaley, and Okero (2013), across four studies representing almost 270 children from 12 countries, predominant reactions are sadness (41.64 %) and worry (23.42 %). These children may be traumatized and suffer psychological reactions to maternal illness: enduring fatigue, fear, and stress from worry and insecurity and enduring stigmatization and social isolation (Richter, 2004)—all of which impact current and future functioning and mental health. Such stress can impact children's sleep patterns, eating habits, academic progress, social interactions, and self-esteem.

Even for children who may not be aware of their mother's HIV serostatus, children of MLH have significant problems. A majority (68 %) of children living with an HIV-positive mother was classified as non-resilient in one study and had poorer coping self-efficacy and more depressive symptoms (Murphy & Marelich, 2008). Multiple studies have demonstrated that parental HIV is associated with negative outcomes for children (e.g., Bauman, Silver, Draimin, & Hudis, 2007; Hough, Brumitt, Templin, Saltz, & Mood, 2003; Murphy & Marelich, 2008; Murphy, Marelich, & Herbeck, 2012; Reyland et al., 2002).

Are younger children of HIV-infected mothers living with HIV/AIDS more at risk for anxiety and depression than older children?

Long-term, children affected by maternal HIV are more withdrawn and show higher levels of depression, although a good parent–child relationship may mitigate this (Bauman et al., 2002; Forsyth, Damour, Nagler, & Adnopoz, 1996; Tompkins & Wyatt, 2008). Over 2 years, Bauman et al. (2007) found that every uninfected 8–12-year-old child of an MLH had clinically significant psychiatric and/or behavioral symptoms, with two thirds having chronic problems, although few received any type of service. In a 12-year longitudinal study, maternal health status (i.e. viral load, illness symptoms, and physical functioning) had a negative effect on child/adolescent outcomes of depression, anxiety, and self-concept, with younger children more impacted by poor maternal health than older children/adolescents (Murphy, Marelich & Herbeck, 2012). Psychosocial functioning of adolescents affected by maternal HIV/AIDS, in terms of their relationship with their mother, was negatively impacted by maternal illness; moreover, several indicators of increased maternal illness predicted less attachment with peers (Murphy, Marelich, Lanza, & Herbeck, 2012).

Overall, studies suggest that children living in families affected by maternal HIV/AIDS demonstrate higher rates of maladjustment. They have more difficulties in most domains of psychosocial adjustment relative to children in families with no parental illness (Forehand et al., 1998; Forsyth et al., 1996). The risk for poor psychosocial outcomes in children living with an HIV-positive parent extends through middle adolescence, with younger children more impacted than are older children (Murphy, Marelich & Herbeck, 2012; Reyland et al., 2002).

Children affected by maternal HIV/AIDS have been vastly neglected in the HIV/AIDS response (e.g., Bhana, 2009; King, De Silva, Stein, & Patel, 2009; Richter et al., 2009). HIV-related disruptions in parenting predict poor child outcomes unless strong protective factors are in place. Moreover, children of MLH are already vulnerable for poor outcomes due to disproportionately low-income and living in areas with high crime rates. Parenting skills among families affected by maternal HIV dealing with parenting stress may be especially critical to improve both MLH and child outcomes. Many investigators in this area have contended that while parenting intervention can be highly helpful for all mothers, it should be a priority for MLH, yet almost no controlled studies have been conducted.

5.3 Findings for Middle East Replication

For 15 years (1997–2013), a sample of mothers living with HIV and their children were followed by a University of California, Los Angeles research team. The *P*arents *A*nd children *C*oping *T*ogether (PACT) study was designed to longitudinally assess MLH and their young, children age 6–11 years of age, to investigate child outcomes. A subsequent longitudinal study, "*P*arents and *A*dolescents *C*oping *T*ogether" (PACT II), followed the majority of these families as the children transitioned to early and middle adolescence. A third study, PACT III, followed the children one last time, as they transitioned to late adolescence/early adulthood.

Utilizing PACT findings, a self-care and parenting intervention for MLH was developed: *I*mproving *M*others' parenting *A*bilities, *G*rowth, and *E*ffectiveness (IMAGE). The intervention was reviewed and revised based on Community Advisory Board feedback prior to the pilot trial (this board consisted of PACT mothers).

5.4 Key Components of IMAGE Developed from PACT Findings

5.4.1 Parenting Skill and Child Outcomes

What are the key parenting components necessary for effective functioning identified from the PACT study?

Family Routines. Such routines are critical in the establishment of children's sense of predictability and security and are linked to academic achievement and fewer behavioral problems. Among PACT families with more frequent family routines, children showed lower rates of aggression, anxiety, depression, as well as increased self-concept (Murphy et al., 2009). Parenting interventions for MLH need to

provide the skills for implementation of family routines and assist with strategies for older children or other support figures to maintain family routines if MLH are unable due to illness, hospitalization, or fatigue.

Parentification. In PACT, maternal depression was found to be associated with MLH less able to perform typical tasks; young children of more depressed MLH had increased responsibilities for household tasks. These tasks often inappropriately "parentify" the child. However, McKee et al. (2007) found that a positive mother–child relationship was protective among an HIV-infected sample group of mothers when maternal depressive symptoms were high. PACT investigated current autonomy among early and middle adolescents affected by maternal HIV, predicting autonomy from children's responsibility taking when they were younger (age 6–11) in response to their mother's illness (Murphy, Greenwell, Resell, Brecht, & Schuster, 2008). Children with greater attachment to their mothers had higher autonomy. Furthermore, children who had taken on more responsibility directly because of their mother's illness when they were young showed better autonomy development as early- and middle-age adolescents; these findings were similar to those of Tompkins (2007). Therefore, "parentification" of young children with a mother with HIV may not negatively affect later development. But the impact of parentification may be very dependent on the parent–child relationship and the level and type of the tasks assigned to the children. Parenting interventions for MLH need to provide information on developmentally appropriate child responsibilities and how to determine when a child may learn and profit from the increased responsibility, rather than be overwhelmed by the associated demands. In addition to assistance in determining what responsibilities are age appropriate, interventions should provide guidance to MLH on obtaining support and assistance during times when they are unable to fulfill the parenting role, especially when the child would not be the appropriate person to assist. In working with MLH over the past 15 years, it was found that such women often are unaware of appropriate developmental tasks. These could be due to the possibility that they were inappropriately parentified when young.

Parental Monitoring. Lack of parental monitoring is associated with later-onset delinquency (Steinberg, 1987). HIV-infected mothers are less likely to monitor their children compared to noninfected mothers (Kotchick et al., 1997). Among PACT families with higher levels of parental monitoring, children showed lower rates of anxiety, depression, conduct disorder, heavy drinking, and increased self-concept (Murphy et al., 2009). In addition, it was found that children in families with greater variability in parental monitoring due to MLH health fluctuations over time showed higher levels of depression and conduct disorder and lower academic self-image.

Why is maternal self-care critical for effective parenting—and thus child outcomes?

Parent–Child Communication. As far back as Baumrind's early study on child care practices and preschool behavior (e.g., Baumrind, 1967), it has been clear that parents of young children who exhibit the most functional behavior tend to communicate more clearly with their children. In recent meta-analytic reviews investigating the components associated with parent training program effectiveness, one that was consistently associated with larger effects is positive parent–child communication skill (CDC, 2009; Kaminski, Valle, Filene, & Boyle, 2008). It was found that good parent–child communication is critical for improving child outcomes, including lower anxiety and depression, better self-esteem, and reduced behavior problems (e.g., Murphy, Armistead, Marelich, Payne, & Herbeck, 2011; Murphy, Marelich, Graham, & Payne, 2015).

Mental Health Strategies: *Depression and Stress*. One of the first PACT studies investigated the functioning of MLH (Murphy, Marelich, Dello Stritto, Swendeman, & Witkin, 2002). A higher level of maternal depression was associated with poorer cohesion in the family and with poorer family sociability. Depression also was associated with mothers being less able to perform tasks that they typically do; children of more depressed mothers had increased responsibilities for household tasks. MLH exhibit more depressive symptomatology than uninfected mothers, and Latina mothers and their children were at increased risk for both depression and anxiety symptoms, particularly in families where the mothers were not born in the USA (Brackis-Cott, Mellins, Dolezal, & Spiegel, 2007). Finally, McKee et al. (2007) investigated interactions between maternal depressive symptoms and protective correlates of depressive symptoms among inner-city African-American children of mothers with HIV. They found that a positive mother–child relationship was protective among the HIV-infected sample of mothers when maternal depressive symptoms were high.

Parenting stressors are strongly related to maternal mental health. In a national sample comparing mothers with and without parenting stressors, mothers reporting one stressor had 3 times the odds of poor mental health, and mothers reporting two or more stressors had nearly 12 times the odds (Mistry, Stevens, Sareen, De Vogli, & Halfon, 2007). Specific to MLH, those who are anxious about their own health and functioning, as well as more stressed in their parental role, are more likely to have poorer parenting skills. That is, they engage children less frequently in family routines, have poorer parent–child communication, and exhibit poorer and less consistent parenting discipline (Murphy, Marelich, Armistead, Herbeck, & Payne, 2010). Parenting interventions for MLH need to provide information on how psychological distress can affect family functioning and child outcomes and provide strategies and support for dealing with psychological distress and parenting stress.

Mental Health Strategies: *Social Support and Disclosure*. Lack of social support has been identified as a stressor linked to increased risk of poor maternal mental health among mothers with young children (Mistry et al., 2007). HIV-positive mothers who have adequate social support are physically and mentally healthier over time (Ashery, Robertson, & Kumpfer, 1998). To obtain support HIV+ women

often need to consider disclosure of their HIV status. Disclosure decisions impact mental health (Cederfjall, Langius-Eklof, Lidman, & Wredling, 2002; Serovich, 2001) and health behaviors. Nondisclosure creates a milieu of secrecy that may make developing and strengthening social networks more difficult (Asander, Belfrage, Pehrson, Lindstein, & Bjorkman, 2004; Kalichman et al., 2006; Klitzman et al., 2004). HIV-positive mothers need support, and those with social support are physically and mentally healthier over time (Ashery et al., 1998). Disclosure needs to be discussed in two contexts: disclosure to other adults to obtain social support and disclosure to the child.

Mental Health Strategies: *A. Disclosure to Other Adults*. HIV disclosure, although a stressor, facilitates emotional support, which may lead to more effective coping and psychological adaptation (Holt et al., 1998). Simoni, Demas, Mason, Drossman, and Davis (2000) found disclosure among HIV-positive women was related to higher frequency of HIV-related social support, and disclosure rates were positively associated with the use of more adaptive coping strategies. Among both HIV-positive women and men, rates of disclosure have found to be associated with social support (Kalichman, DiMarco, Austin, Luke, & DiFonzo, 2003), with friends disclosed to most often and perceived as more supportive than family members, and mothers and sisters disclosed to more often than fathers and brothers due to being perceived as more supportive than other family members.

Mental Health Strategies: *B. Disclosure to Children*. MLH who disclosed to their children reported higher levels of social support (Murphy, Steers, & Dello Stritto, 2001). Children whose mothers had disclosed displayed lower levels of aggressiveness and lower negative self-esteem. Using longitudinal observational data, analyses of depression and anxiety score for children of MLH, before, during, and after disclosure: children showed significant improvement on mental health variables following disclosure (Murphy, 2008). The *T*eaching, *R*aising, *A*nd *C*ommunicating with *K*ids (TRACK) program was a longitudinal pilot-trial intervention designed to assist MLH disclose their serostatus to their young children. MLH in the intervention group were six times more likely to disclose their HIV status than those in the control group (Murphy et al., 2011). MLH in the intervention group showed increases in disclosure self-efficacy across time and improvement in emotional functioning. Among the children of the intervention group mothers, communication increased significantly according to the parent attachment measure. In addition, children of MLH in the intervention group showed significant reductions in depression and anxiety and increases in happiness.

Physical Health Strategies: *Adherence to Physical and Mental Health-Care Routines*. Poor rates of medication adherence were found among the PACT MLH (Murphy, Greenwell, & Hoffman, 2002), ranging from 43 % (pill count) to 56 % (self-report). Factors associated with nonadherence included perceived stress, age of youngest child, poor self-efficacy to follow treatment regimens and recommendations, and poor outcome expectancies. The two barriers most frequently reported were being busy with other things (28 %) and forgetting (26 %), which could be related to these women's roles as mothers. It was found that one way to

improve MLHs' self-care is to show them it relates to important child outcomes. In a longitudinal study of the relationship between MLHs' physical health and children's psychological well-being over a 6-year period (Murphy, Greenwell, Mouttapa, Brecht, & Schuster, 2006), lower levels of physical functioning and more physical symptoms among mothers were associated with significantly higher child depression, anxiety, and aggressive behavior. MLH health stability is associated with better and more rapid improvement in child mental health indicators. Thus, interventions for MLH need to provide them with information on how their physical health can influence family functioning in order to motivate them to improve personal health care, but also provide them with strategies for obtaining support and managing health.

5.5 The IMAGE Intervention

The information, motivation, and behavioral skills model (IMB; Fisher & Fisher, 1992) is a leading theory that suggests social-cognitive variables such as attitudes, knowledge, and social norms predict a wide range of health outcomes. The model initially was focused and tested in interventions addressing HIV prevention and risk reduction (e.g., Anderson et al., 2006; Bryan, Fisher, & Benziger, 2001; Fisher, Fisher, Misovich, Kimble, & Malloy, 1996). However, it has since been used extensively for other health research, including breast cancer self-examination (Misovich, Martinez, Fisher, Bryan, & Catapano, 2003), adherence to highly active antiretroviral therapy known as HAART—"highly active antiretroviral therapy" (e.g., Starace, Massa, Amico, & Fisher, 2006), and sexual communication between adolescent girls and their mothers (e.g., Aronowitz & Munzert, 2006; Aronowitz, Rennells, & Todd, 2005). In IMAGE, the model was applied to the parenting behavior and self-care skills of HIV-positive mothers. Thus, skills targeted in the intervention with the MLH are those in the center box ("Parenting & Self-Care Behavior; see Fig. 5.1 below). The maternal, child, and family outcomes presented to the far right in the figure are the factors anticipated to improve based on participation in the intervention. The IMAGE intervention was developed to improve the parenting and self-care skills of MLH, with the ultimate aim of enhancing maternal, child, and family outcomes. A brief description of the content of each of the intervention sessions follows.

Intervention Description. The individualized intervention consists of four sessions and allows for developmental tailoring for MLH of children age 6–14. The following overview below shows the content of each of the four sessions.

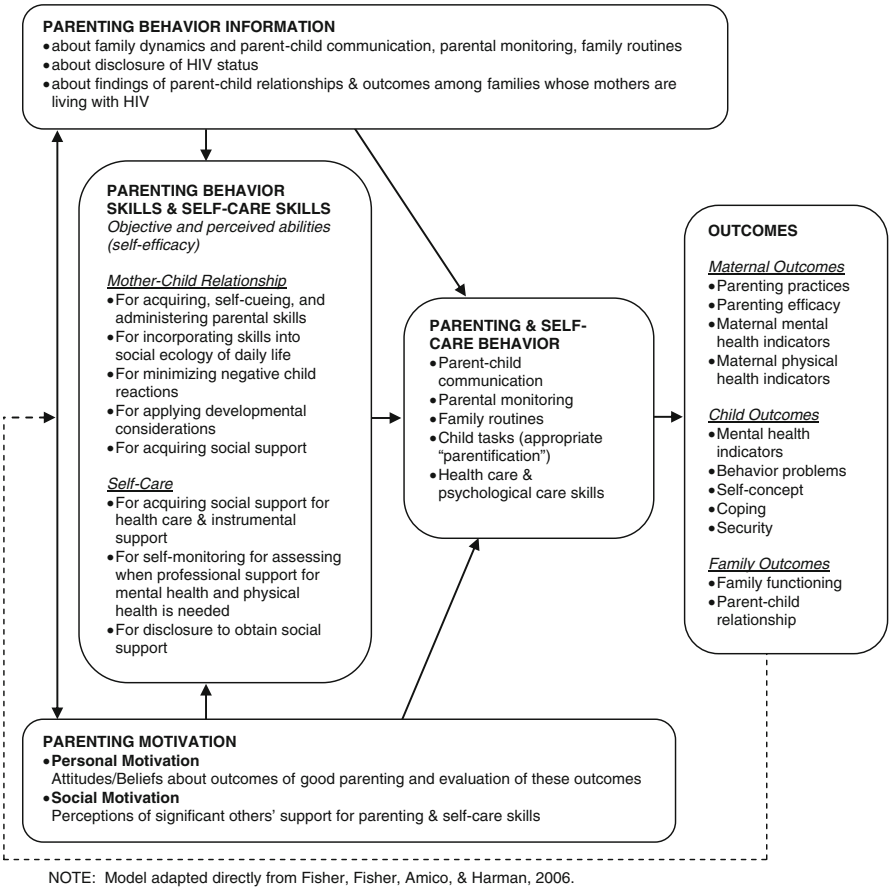

Fig. 5.1 IMAGE: parenting efficacy

_I_mproving _M_others' Parenting _A_bilities, _G_rowth, and _E_ffectiveness (IMAGE)

Session 1: Introduction to the IMAGE Program and Findings from Previous Studies with HIV+ Moms

1. *Introduction to program*

   (a) Improving Mothers' parenting Abilities, Growth, and Effectiveness (IMAGE)

   - What is image of self, of mother role, and of other roles?
   - What are MLH's challenges in combining maternal role with physical and psychological demands of being HIV+?

- Purpose of program: to support growth, especially in challenge of living with HIV and raising children.

(b) Format of each session; overview and ground rules

2. *Developmental issues*

(a) Developmental checklist—examples of child capabilities across developmental stages
(b) Challenging children appropriately (beginning of issue of appropriate "parentification")

3. *Good parent–child communication*

(a) Importance of mother–child communication in child development
(b) Discussion of current mother–child communication (status, positives, and problems)
(c) The what, when, where, and how of good parent–child communication
(d) Behavioral planning for improving mother–child communication

4. *Child resiliency*

(a) What is resiliency in children?
(b) What are ways to try to improve resiliency in children?

- Discussion of having strong adult figures in child's life ("just mom," vs. mom + support)
- Child problem solving, self-concept, and social skills

(c) Behavioral plan for improving child resiliency outcomes.

5. *Summary and behavioral practice plan for the week* (*communication exercise*, *resiliency planning*)

Session 2: Importance of Moms' Self-Care and Impact on the Family

1. *Mom's health* (*physical and mental*) *and its impact on children*

(a) Mother's experiences about how her health and emotional well-being influences her children
(b) Mother's daily functioning and child outcomes
(c) What we know about this from other HIV-positive mothers

2. *Mom taking care of self*, *in order to take care of the children*

(a) General self-care, health-care appointments, and medication adherence (where applicable)

- Discussion of how mother is doing in these areas
- Basic strategies that could be incorporated to fit her lifestyle for general health care

Simple reminder strategies
Self-monitoring strategies
Reinforcement strategies

(b) Taking care of your mental health

- Status of social support and acquiring social support when needed
- Community involvement times when professional support is needed
- Times when professional support is needed

(c) Behavioral planning for physical and mental health, referrals as needed

3. *Summary and behavioral plan for week* (*mom's care—taking time for self, self-care behavioral plan*)

(a) Select a physical or mental health issue and tailor the plan to something that can be accomplished.
(b) Family routines are for a child to feel secure and stable earlier today. If you let yourself get run down and become ill, then that is a good example of when family routines can fall apart.
(c) Remember, taking care of yourself is a key priority for both you and your child.

Session 3: Good Family Practices to Strengthen Protection for Children

1. *Good family practices*

(a) Family routines

- How are kids with regular/stable family routines different than those who don't have that?
- Ways in which to start, or to improve, stable family routines.

(b) Parental monitoring

- How are kids who parents monitor them different than those whose parents don't?
- Types of monitoring.
- Monitoring through caring, not punitively.

(c) Assigning tasks to children when you need help: how to judge appropriately

- "Parentification"—when is it character building , and when is it harmful to a developing child?
- Relate to issue of family routines—when is it helpful to obtain other family or outside (agency) support in cases where mother cannot implement stable routines?

2. *Mom's self-care*
   (a) Review of progress
   (b) Importance of partnering with health-care provider to obtain best outcomes
   (c) Additional strategies for general self-care
   - Cognitive strategies
   - Cognitive behavioral strategies
3. *Summary and behavioral practice plan for the week* (*starting or strengthening family routines*)

Session 4: Progress and Future Directions for Moms ' Own Self-Care

1. *Stigma*: *how does it affect HIV+ women*; *how does it affect you and*, *in turn*, *your children*?
   (a) Dealing with stigma (identifying and confronting automatic negative thoughts and reframing, stress management strategies, desensitization to feared stimuli, cognitive challenges, emotional writing)
   (b) Dealing with children's concerns about stigma
   - What we know about how young children perceive stigma
   - Fears of "stigma by association" and dealing with these fears
2. *Importance of social support*
   (a) Social support: findings from other MLH
   (b) Status of current social support
   (c) Strategies for expanding social support (e.g., identify service agencies in neighborhood, identify best neighborhood friend, utilize the web, invite HIV+ mom for coffee, etc.)
   (d) Behavioral plan for expanding or strengthening social support ties
3. *Disclosure*
   (a) Pros and cons of disclosure
   (b) Selecting targets for disclosure likely to have good outcomes
   (c) What other women living with HIV have said/experienced about disclosure and their advice
   (d) How to handle different reactions to disclosure
   (e) Questions you might be asked if you disclose: preparation
   (f) Behavioral practice and planning for disclosure
4. *Summary and behavioral plan for the week* (support and disclosure targeted; and, where applicable, plan for improving perceived stigma)

Session 5: Revisit IMAGE Issue

1. *Throughout*, *homework assigned*: *challenging*, *stressful*, *irritating*? *Benefits*?
   (a) How is image of self as "mother" changing and growing?
   (b) What is final image she wants to be as a mother?
   (c) Reinforcement for moving toward goals.
   (d) Review of progress.
2. *Putting it all together*
   (a) Parenting skills linked to mom's physical and mental health/well-being
   (b) Behavioral homework that has worked well and what has not worked as well
   (c) Final planning for long-term efforts

IMAGE challenges the mother to make a better family. It promotes one step forward and improving things even more—that's what IMAGE is about. IMAGE is about always looking in the mirror and asking how to do better as a mom.

5.6 IMAGE Findings

Was the IMAGE pilot intervention study found to be more effective than standard care?

The pilot IMAGE study findings were very promising. The IMAGE pilot assessed 62 families (62 MLH and 62 children age 6–14 years; total $N = 124$) at baseline and 3-, 6-, and 12-month follow-ups. MLH were randomized to intervention or control. The IMAGE pilot intervention consisted of four intervention sessions. In terms of self-care, significant positive intervention effects were found for self-care self-efficacy, physical self-care, positive affect, and lower anxiety. In terms of parenting, significant positive intervention effects were found for parenting efficacy, parenting practices, parenting skills, parental involvement, positive parenting, parental monitoring, family routines, and parent–child communication. Child outcomes supported maternal results in terms of children also reporting improved family routines and parental monitoring. In addition, post-intervention, children of intervention group mothers (compared to control children), had lower depression scores and improved mother–child communication. This pilot trial demonstrated the intervention's promise: IMAGE had a consistent, positive impact on parenting

skills and on many of the maternal, child, and family outcomes based on MLH report. Furthermore, child reports frequently confirmed maternal reports of intervention impact. These findings and their implication will be briefly discussed. In addition, a subset of MLH who were randomized to the intervention underwent in-depth qualitative debriefings following the intervention and final follow-up assessment, and these clinical findings will also be reviewed briefly.

5.6.1 Maternal, Child, and Family Outcomes

As shown in Fig. 5.2, mothers receiving the IMAGE intervention reported better outcomes than control MLH in several areas including better parenting practices (e.g., maternal involvement, use of positive reinforcement) and better perception of their ability to parent effectively (parenting self-efficacy) than those not receiving the intervention MLH. Child reports of maternal involvement confirm mothers' reports. Beyond involvement, children of MLH in the intervention reported trends in the same direction at 12-month follow-up for monitoring and 6-month follow-up for routines and significant effects for parent–child communication at 6-month follow-up with the trend persisting at 12 months. This pilot study indicates that the IMAGE program confers important benefits to MLH as well as their children.

The child outcomes anticipated to result from better parenting, based on PACT and other research, were also observed in the pilot study. MLH assigned to IMAGE and their children reported less aggression than control children. What is more, the intervention children had significantly fewer depressive symptoms than those not receiving the intervention (i.e. controls) at 12-month follow-up. Finally, IMAGE children also reported significantly better coping and trends for better self-concept than control children (Fig. 5.3).

It is clear with respect to both parenting and self-care skills that it took time for MLH to integrate the skills into daily life. Specifically, the skills targeted in the intervention improved over time. Not surprisingly, the same can be said for the

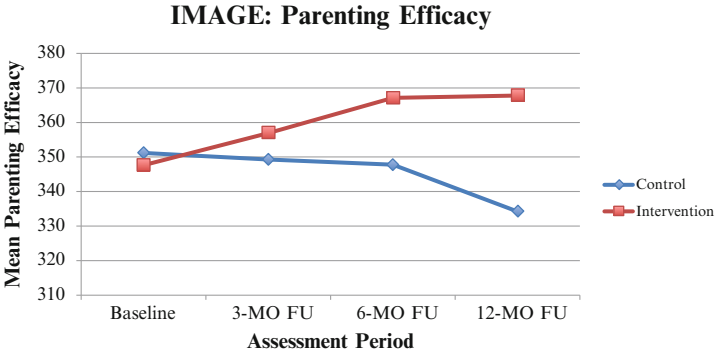

Fig. 5.2 IMAGE: parenting efficacy

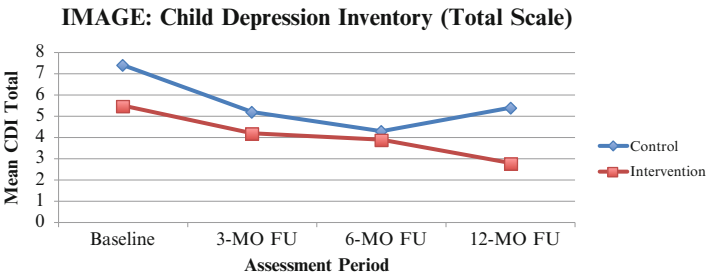

Fig. 5.3 IMAGE: Children Depression Inventory (total scale)

maternal, child, and family outcomes. Changing parenting and self-care behaviors and breaking long-held habits in both of these domains is a challenging process, particularly in the context of illness demands. Beyond the time it may take MLH to use and incorporate skills and changes, it may take time for children to observe and benefit from a parent's effort to change behavior. Thus, it is not surprising that the data reflect gradual improvements in skills and the outcomes of those skills over time. Possibly related to this are the limited results related to family outcomes, such as family cohesion and overall parent–child relationship. Based on trends in a positive direction on these variables, it is likely that mothers and children need more time for the skills acquired to result in family-level benefits. Most of the families in this sample are socially and economically compromised above and beyond the challenges associated with HIV. Change in relationships and confidence in the stability and reliability of those changes could take more time than that associated with individual-level variables. The significant findings on maternal dependability and trends for security and relationships, all reported by children, are viewed as strong preliminary evidence for the IMAGE program's potential to promote change in families that is recognized by children and, ultimately, reflected in their outcomes.

Though somewhat offset by the finding that MLH in IMAGE had fewer anxiety symptoms following intervention participation, IMAGE seemed less effective in affecting levels of depressive symptoms. Although it should be noted that depression scores for the MLH intervention group were lower at 12-month follow-up, relative to baseline, which was not observed in the control group, differences between intervention and control groups were not statistically significant. Given the demonstrated associations between HIV infection and depression, as well as the impact of maternal depression on children, enhancements to IMAGE aimed at increasing the intervention's ability to impact depression may be warranted. However, the lack of a difference in depression between groups led us to further investigate this area and also analyzed a secondary measure of depression (data not shown). MLH in both conditions evidenced only mild depression per clinical cutoffs on the depression scale. So it may be that since the sample was not meaningfully depressed, the intervention was not particularly needed in terms of reduction of depression.

5.6.2 Targeted Skills: Parenting and Self-Care Behaviors

MLH in the intervention condition reported significant improvements in three of the four targeted parenting skills: parent–child communication, monitoring, and family routines—relative to control MLH. Notably, these effects persisted and were in fact stronger, at 12-month follow-up. There were no differences in parentification of children, comparing the intervention group relative to controls, indicating that either the intervention's content on appropriately assigning child tasks was inadequate or the measurement of this construct was insufficient. Either way, the intervention's positive impact on the skills most consistently linked with better child outcomes (communication, monitoring, and routines) and the persistence of those skills at 12-month follow-up are impressive, particularly given the small sample size used in this pilot study.

IMAGE was better able to induce improvements in parenting skills than in personal self-care skills, and on top of that, significant improvements in self-care were not reported until the 12-month follow-up. The strongest findings were those associated with physical functioning, relative to self-care associated with psychological functioning. Improvements in self-care around physical functioning were similar to findings associated with maternal outcomes. Specifically, MLH in the intervention condition reported less pain than those in the control group, but only trends for differences between control and intervention groups were present for most mental health outcomes. Anxiety and positive affect were exceptions to this rule, with the intervention MLH presenting better outcomes than control MLH in both domains by 12-month follow-up. It is not surprising that mothers' reports are indicative of better and faster uptake of intervention components focused on improving parenting, relative to those focused on self-care, as mothers regularly prioritize needs they perceive as most directly relevant to their children over their own needs.

5.6.3 Clinical Findings from Debriefings with MLH Who Were in the IMAGE Intervention

A subset of MLH who were randomly assigned to the IMAGE intervention condition were administered an in-depth debriefing following their participation in the intervention and final assessment. This qualitative interview was administered by an interviewer that had not been associated with the IMAGE intervention, so MLH would feel free to discuss their views of the intervention content and format, how much they had utilized the intervention techniques following study participation , and their overall views of the project. A number of important themes regarding the intervention effectiveness emerged. Selected quotes to illustrate these themes are reviewed here:

> One 38 year old African-American MLH with a 8 year old male child discussed the change in communication in her family. "Because I had noticed…that I did not communicate with

my kids very well…We've actually built a different communication relationship that we didn't have before…so it definitely made me take a look at the things I was not doing correctly…We actually—it's still not perfect, but I feel like I'm a better mother because I learned a little bit how to communicate with him a little bit better…I feel like I use the tools. I feel like they were effective and that I use them more every day, so I think it just—every day it helps me improve the way I talk to my kids, the way I deal with my family…I always like a conversation about this—that you're not being told you have to do something, but I liked that I came it as tools. These are tools to help you when the situation arises, so you can look at it later."

Another African-American 31 year old MLH with an 11-year old female child said: "…some children move slower than others, some develop faster than others. It also showed me that I got to learn that each child has their own different personality, and I got to work with them differently. Because one may seem that she's more advanced than the other, don't mean that—so I had to work with them differently and that helped….Then they also told me that if you're upset about something, don't go try to talk to your child right then and there because you could probably lash out at them….I got that too. When I'm mad at them or they got me highly upset, I will go calm down then come back and—I mean, go and get my train of thought together, then I'll come back and talk to them….But I love the program 'cause I got a lot out of it. It taught me how to listen when they're talking….I used to be a drug addict. I wasn't home—I wasn't around my kids for a while, and I had just come back about a year ago and I was pregnant….I had to learn my children all over again….We're starting to come around. We're starting to have mother/daughter days. We go to—we all went to Denny's and we all sat and ate, had us a little fun. I try to do things with them like that, to show them okay, Mom love them. Like, just my daughter the other day bought me a bouquet of flowers and put on there, 'Mom, yes Mom, I love you.' I don't know what made her do it. But just to show that—that feeling right there is, okay, I'm being appreciated."

This mother had also focused on the self-care piece of the IMAGE intervention, as indicated by the following quote. "Yeah, because I can't be sick and—I mean a mother needs to make sure that her health is stable and things like that because—you know what I'm saying? Ain't nobody gonna take care of your children as good as you can, you know what I'm saying?.... mother's got to keep themselves right….Lately I've been—if I'm dealing with certain situations, even if it's in my car, I will sit in my car for a few minutes before I leave and will take a deep breath and just relax. A clarity moment, that's what you would call it. I will just sit there and I'll just relax and just listen to my surroundings and just meditate on certain situations. By the time I'm done, I feel a little—I feel—maybe not be 100 percent better, but I feel a little better."

Another MLH found the disclosure training in IMAGE very helpful. This Latina 46 year old MLH with an 11 year old female child stated: "I have learned a lot from this IMAGE program. I think every mother, not just mothers that are infected—this is a good thing for every mother….It was so funny when I got introduced to this IMAGE program, because I was….in my point of life where I was feeling….I need to tell them.' I just didn't know how to go about it. When I told her *[her daughter]*, I just felt like a whole brick wall came off of my back. I didn't realize that I was carrying that brick wall until that happened. And I told her. I just felt like 100 pounds lighter. It was so awesome."

Finally, an African-American 46 year old MLH with a male child age 9 also commented on the benefits of the program: "This really has made me a stronger person. It made me really see that I could still be a mom. I don't have to worry about no stumblin' blocks, or people sayin' this about this. It doesn't bother me. It just motivates me to keep movin' on. I know that what I'm doin' is good, and it's helpin' me. It's helpin' my family….we didn't bond like we really had s'posed to, because there was a lot of things missin'. When I got involved in this, and I seen a lot of things, and I took the information and I applied it, it made it come together. It has come together even *[sound of fingers snapping]* more stronger….it teaches power . You can still live with this. You can still live, long as you eat healthy, take your medication, and do what's right by you. Keep a support group. Stay positive no matter what. You can live. You can live. You can do just about anything that anybody else can do."

5.7 IMAGE Summary

The families enrolled in the IMAGE pilot trial were challenged by maternal illness, low-resource environments, and socioeconomic restraints. Most are at risk for experiencing stigma, discrimination, and marginalization that accompanies being an ethnic minority living with a stigmatized illness. Despite all of this, many of the families benefited from the IMAGE intervention. Within only four brief sessions, MLH were able to change and sustain change in parenting behaviors and initiated change in self-care behaviors within a year of receiving the intervention. Many maternal and child outcomes showed the beneficial outcomes of these behavioral changes. Growth in communication across time was associated with intervention involvement; parental monitoring became significantly better over time; and family routines showed a linear increase over the follow-up time points. Given the large body of research demonstrating relations between maternal HIV and parenting and parenting and child outcomes, interventions like IMAGE are urgently needed.

5.8 Conclusion

The IMAGE intervention was developed for mothers living with HIV/AIDS who had children; however, it is generally applicable to a wide range of parents dealing with any type of disease or disorder. It may be very applicable for parents with a substance use disorder. Several studies have shown that most women entering into substance abuse treatment are mothers (Conners et al., 2004; Grella, Scott, Foss, Joshi, & Hser, 2003), and injection drug using mothers have been found to be more likely to enter methadone maintenance treatment if they are living with their children, compared to mothers not residing with their children (Lundgren, Schilling, Fitzgerald, Davis, & Amodeo, 2003). And for substance-using mothers who are incarcerated, child-welfare involvement has been associated with higher motivation to enter treatment, suggesting that participation in interventions may be critical to reunification with their children (Grella & Rodriguez, 2011).

5.9 Future Directions

The IMAGE program was adapted/tailored for Israeli and Palestinian chronically ill (including substance using) parents, but not yet tested for that population. However, there is some evidence that family programs such as this may be effective in such a population. For example, the SHIELDS for families' Exodus Therapeutic Community (Icenhower, 2013) has been found to be effective among substance-using parents. It is a very intensive and comprehensive program covering individual, family/collateral, and group counseling, mental health services, case management, life skills, health education, family reunification, family support, and relapse prevention. However,

such all-inclusive services can be cost and personnel prohibitive for many communities needing assistance/services, especially those in the Middle East region. The IMAGE program, which is a brief, family-focused program, may be useful to such communities providing it is modified for cultural differences.

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Chapter 6
Substance-Abusing Mothers: Toward an Understanding of Parenting and Risk Behavior

Mor Yehudai, Orly Sarid, Alexander Reznik, Patricia A. Findley, and Richard Isralowitz

6.1 Introduction

As of 2012, in the United States, there are more than 8.3 million children under the age of 18 who lived with at least one parent who was dependent either on alcohol or drugs during the past year (SAMHSA, 2009). Parents who are active users of alcohol and drugs are known to have impaired parenting skills which, in turn, can make a dysfunctional family dynamic even worse (Dunn et al., 2002). This issue is not specific to the United States. Meyers et al. (2014) found that for emigrants from the former Soviet Union (FSU) into Israel, parental alcohol problems predicted alcohol, nicotine, and cannabis use disorders, antisocial personality disorder, major depressive disorder, and post-traumatic stress disorder (mean ratios = 1.38–4.83). In non-FSU Israelis, parental alcohol problems predicted only antisocial personality disorder, major depressive disorder, and post-traumatic stress disorder (mean ratios = 1.08–4.09).

Parenting by substance abusers can be chaotic, inconsistent, and unpredictable (Kelley, 1998; Myers & Isralowitz, 2011). According to Velez et al. (2004), mothers entering drug abuse treatment have limited parenting knowledge and hold misconceptions about basic parenting practices. Lack of knowledge in parenting domains is likely

M. Yehudai (✉)
Spitzer School of Social Work, Ben Gurion University of the Negev, Beer Sheva, Israel
e-mail: moryehu@post.bgu.ac.il

O. Sarid • R. Isralowitz
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel

A. Reznik
Senior Research Associate, Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben Gurion University, Beer Sheva, Israel

P.A. Findley
School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA

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to negatively affect mother–infant interaction, especially during the crucial postpartum period, and thus may affect the development of the child, thereby producing increased feelings of guilt and inadequacy among substance-abusing women. This, in turn, may lead to poor mother–infant communication, developmental delay, child abuse and/or neglect, and relapse to drug use after the baby is born (Velez et al., 2004). As children of substance abusers enter school, there is less likelihood that they will receive adequate help with or monitoring of homework or that their parents will attend parent–teacher conferences (Myers & Isralowitz, 2011). Parental substance abuse is associated with a more than twofold increase in the risk of exposure to childhood physical and sexual abuse (Walsh, MacMillan, & Jamieson, 2003). And, many drug-using women do not seek treatment because they fear not being able to take care of or keep their children, reprisal from their spouses or boyfriends, and punishment from authorities in the community (Isralowitz & Myers, 2011). Furthermore, a study that focused on drug-dependent women in Israel suggests that formal intervention is needed to maintain recovery, such as intervention from the welfare system (Gueta & Addad, 2015).

6.2 Parenting Stress

The term "parenting stress" encompasses the difficulties in adjusting to the parenting role (Leigh & Milgrom, 2008). It is associated with negative parenting practices linked to increased health risk behaviors (Taylor, Rodriguez, Seaton, & Dominguez, 2004). Socioeconomic status is an important determinant of parenting stress. Families in poverty are subjected to chronic stress because of financial strain that diminishes resources needed to deal with daily life. Chronic stress diminishes the psychological well-being of a parent. Those most at risk include parents with low education levels, single parents, parents in poor health, youth with existing problem behaviors, and families with high levels of conflict (Mistry, Stevens, Sareen, De Vogil, & Halfon, 2007; Taylor et al., 2004).

Maternal characteristics are associated with parenting stress and maladaptive coping behaviors; they include child neglect and abuse, problems in mother–child attachment, sense of competence as a parent, social isolation, depression, personal health concerns, and the perception that their child is very demanding. Women who used harmful substances during pregnancy report the greatest amount of parenting stress (Kelley, 1992, 1998) that may be linked to attention deficit and hyperactivity disorder (ADHD) status and young adult nonsuicidal self-injury among their children (Gordon & Hinshaw, 2015).

6.3 A Study: Substance Abuse, Suicide, and Parenting

There is a dearth of information specifically about substance abuse, suicidal ideation, and parenting. Substance abuse and suicide are major self-destructive behaviors strongly linked to risk and protective factors (Borges, Walters, & Kessler, 2000;

Forman & Kalafat, 1998). The exact nature of the relationship between substance abuse and suicide is unclear, but possible mechanisms are that substance abuse: (a) exacerbates the effects of depression and anxiety ; (b) increases isolation from supportive peers, family, and other adults; and/or (c) reduces self-appraisal and inhibitions against problem behaviors. Forman and Kalafat (1998) found comorbid depression and substance abuse were the most frequent individual diagnosis in suicide attempters. In a study of substance abusers in treatment, women were found to be more likely than men to attempt suicide. Those who attempted suicide were more likely to have additional psychiatric diagnoses such as major depression and a higher level of addiction including the abuse of multiple substances, especially alcohol and sedatives, than those who were non-attempters (O'Boyle & Brandon, 1998). The purpose of this study was to identify the impact of personal characteristics of substance-abusing mothers and patterns of substance use on parenting skills.

Study Hypotheses

1. Substance use patterns would not differ according to personal background characteristics.
2. Substance use patterns would not be related to mothers' study responses.
3. Mothers from different demographic backgrounds do not differ in terms of their psychological responses.
4. High levels of suicidal behavior do not exist among the study participants.
5. Mothers who report high levels of suicidal thoughts or attempts do not have higher levels of psychological problems.

Method. The study, based on the work of Professor Debra Murphy, Integrated Substance Abuse Programs, University of California, Los Angeles (Murphy, 2016), was conducted in 2014 at the methadone maintenance clinic in Beer Sheva, located in the southern region of Israel. This region, with about 700,000 population, is often referred to as the country's "barn" for illegal substances.

The study's inclusion criterion was lifetime substance-abusing mothers in methadone treatment. We approached all women with children ($n=61$) and a total of 41 women agreed to participate in the study (response rate—67 %). Personal interviews were conducted by drug treatment center personnel familiar with the mothers. This pattern of interviewing was chosen to create a nonthreatening, non-stressful experience for the participant aiming to achieve honest responses to the questions.

All study participants signed an informed consent stating their rights and safeguards. Information collected from participants was anonymous. The study was approved for ethical purposes by Ben-Gurion University, the Israel Ministry of Health, and the participating methadone maintenance treatment facility.

Sample. Study participants were women receiving outpatient methadone treatment. Methadone hydrochloride is a synthetic narcotic. Once a maintenance level dose is reached, it almost completely blocks the effects of heroin and, thus, controls craving (O'Brien & McLellan, 1996). Methadone treatment is a harm-reduction

strategy that allows the patient to attain a "legal" and productive lifestyle (Israelowitz & Myers, 2011). The drug is usually administered orally as a liquid, once a day usually under the supervision of a clinic staff member. MMT (methadone maintenance treatment) programs are generally similar worldwide. In Israel, MMT has been available with various restrictions for opiate-dependent patients since 1973 (Peles, Schreiber, & Adelson, 2006).

Among the study participants, 22 (54 %) were born in Israel, 16 (39 %) immigrated from the Former Soviet Union, and the rest (3–7 %) were of other origin. Marital status of participants was 35 % single, 20 % married, and 45 % separated or divorced. Regarding educational background, 31 % were elementary school graduates and 69 % completed high school or higher education. In terms of religious orientation, 83 % were Jewish, 10 % Christian, 2 % Muslim, and 5 % of other status.

6.3.1 Research Instruments

1. *Substance Use Survey Instrument* (*SUSI*)—developed by the Regional Alcohol and Drug Abuse Research Center, Spitzer Department of Social Work, Ben-Gurion University. SUSI consists of 31 questions about personal background characteristics, substance use patterns, and risk-taking behavior (Israelowitz, Afifi, & Reznik, 2016). Survey questions include "during the last month have you used alcohol or an illicit substance" and "during the last month have you had 5 or more alcoholic drinks in one drinking occasion." Cronbach alpha = 0.79.
2. *Parenting Stress Index*—short form (PSI-SF) is a 36-item self-report scale used to assess parental distress (PD), parental defensive responding (DR), parent–child dysfunctional interaction (P-CDI), and difficult child behavior (DC) (Putnick et al., 2008). Each item is rated on a Likert scale from 1 to 5 (1 = strongly disagree to 5 = strongly agree). Among the items are "Since having a child, I feel that I am almost never able to do things that I like to do" and "I feel trapped by my responsibilities as a parent." Cronbach alpha = 0.92.
3. *Parent–Child Relationship Inventory* (*PCRI*) assesses parents' perception of their relationships with their children (Steinberg & Silk, 2002). This data instrument consists of four subscales and in the current study, the *Communication Subscale* (9 items) was used. Responses to each item were scored on a Likert scale from 1 to 4 (1 = strongly disagree to 4 = strongly agree). Among the items are "I can tell by my child's face how he or she is feeling" and "My child would say that I am a good listener." Cronbach alpha = 0.68.
4. *Generalized Anxiety Disorder Scale* (*GAD-7*) examines the severity of anxiety (Spitzer, Kroenke, Williams, & Löwe, 2006) using seven items for measurement. Participants were asked how often over the past 2 weeks they had been bothered by each of the seven core symptoms of generalized anxiety disorder (Daig, Herschbach, Lehmann, Knoll, & Decker, 2009; Delgadillo et al., 2012). Each item is assessed on a Likert scale from 1 to 4 (1 = not at all to 4 = nearly every day). Cronbach alpha = 0.79.

5. *Health-Related Anxiety* (*HRA*) is a short, four-item scale assessing health-related anxiety over the past week (Murphy et al., 2001). This scale taps four domains: sleep, appetite, social contact, and concentration at work. Each item is assessed on a Likert scale from 1 to 5 (1 = not at all to 5 = always) (Murphy, Austin, & Greenwell, 2007; Murphy, Marelich, & Herbeck, 2012). Cronbach alpha = 0.78.
6. *The Suicidal Behaviors Questionnaire-Revised* (*SBQ-R*) is a four-item scale (Osman et al., 2002). The first item measures lifetime suicide ideation and suicide attempt. Six answers can be rated from "never" to "really hoped to die." The second item measures frequency of suicidal ideation over the past 12 months, and the answers can be rated on a 5 degree Likert scale (1—never, 5—very often). The third item measures the threat of suicidal behavior. Answers are rated on a 1–5 scale. The fourth item examines the likelihood of suicidal behavior on a seven degree Likert scale (0—never, 6—very likely). (Bryan, Morrow, Anestis, & Joiner, 2010; Ribeiro et al., 2012).

Data Analysis. Statistical analysis was performed using SPSS, version 19 (Chicago, IL). The nonparametric Mann–Whitney U test was used to compare differences between two independent groups.

Results. The first hypothesis states that substance abuse (i.e. type) would not differ according to personal characteristics including marital status, age, country of origin, education, socioeconomic status, religion/religiosity, number of children, and having custody of the children. No statistically significant differences were found between mothers with different personal background and substance use patterns.

The second hypothesis states that substance use type would not be related to mothers' psychological responses. Higher levels of health-related anxiety were found among mothers that used prescription drugs ($U = 117$; $p = 0.033$). As for parent–child communication (PCRI), statistically significant differences were found for alcohol—mothers who used alcohol reported lower levels of parenting skills and negative attitudes toward parenting and their children than non-alcohol users ($U = 112$; $p = 0.024$). Also, significant differences were found between mothers using cannabis and mothers that did not use this substance. Higher levels of PSI values were found among users ($U = 104$; $p = 0.08$). Higher levels of parental distress (PD) were found among mothers who use cannabis compared to nonusers ($U = 101.5$; $p = 0.007$). And, higher levels of defensive responding (DR) were found among mothers who used alcohol ($U = 118.5$; $p = 0.037$), cannabis ($U = 91$; $p = 0.03$), and LSD ($U = 40$; $p = 0.046$) compared to nonusers.

The third hypothesis stated that mothers with different demographic background characteristics do not differ in their psychological responses. No statistically significant differences were found.

The fourth hypothesis stated that suicidal behavior (i.e. thoughts and/or attempts) is not an issue among substance-using mothers in treatment. We found high levels of suicidal behavior. Details found include 22 % of participating mothers had suicidal thoughts throughout their lives, 7 % at least once had a plan to kill themselves but did not try to do it, and 15 % attempted to kill themselves and really hoped to die. In terms of suicidal ideation, 28 % of mothers reported thinking about killing

themselves at least once throughout the past year. When asked about the likelihood of ever attempting suicide, 5 % of mothers reported that they are "likely" to attempt suicide, 5 % are "rather likely" to attempt suicide someday, and another 5 % reported they are "very likely" to attempt suicide someday.

The fifth hypothesis addressed the link between suicidal thoughts or attempts and psychological difficulties. Significant differences in anxiety levels (GAD 7) were found particularly among mothers who reported high levels of suicidal thoughts and attempts ($U=127.0$, $p=0.030$; $U=92.0$, $p=0.011$). Mothers who affirmed suicidal thoughts or attempts had higher levels of health-related anxiety ($U=99.54$, $p=0.004$; $U=100.5$, $p=0.021$), stress about parental role (PD) ($U=113.5$; $p=0.012$; $U=83.0$, $p=0.005$), parental stress (PSI) ($U=100.0$, $p=0.004$; $U=71.0$, $p=0.001$), and defensive responding in terms of gaining the child's cooperation and/or managing the child's behavior (DC) ($U=132.5$, $p=0.041$; $U=82.0$, $p=0.004$).

6.4 Study Conclusions

This exploratory study assessed and evaluated psychological responses and parenting skills among substance-abusing mothers receiving methadone maintenance treatment. We express our gratitude to Dr. Murphy for sharing her expertise in parenting skills among mothers with chronic disease.

Our findings show that mothers using alcohol, cannabis, and LSD have more stress about their role as a parent. These findings are consistent with other studies showing maternal characteristics, especially substance dependence, related to parenting stress and child maltreatment including abuse and neglect (Kelley, 1992, 1998). Parental substance abuse interferes with supportive parenting by impairing awareness of and sensitivity to environmental and child cues and by disrupting emotion regulation, judgment capacity, and executive functioning. Such conditions, including a lack of monitoring and supervision, may be linked with child neglect, sexual abuse, and food insecurity (Widom & Hiller-Sturmhofel, 2001).

Present findings are consistent with those from prior studies showing that mothers heavily involved in drugs experience more difficulties with their children, especially regarding control of the child (Kandel, 1990). In a study conducted by Mowbray, Oyserman, and Ross (1995), mothers suffering from mental illnesses were interviewed about parenting behaviors and attitudes. One-fourth of these mothers reported feeling that disciplining their children was the hardest thing about being a mother. Almost half reported feeling bad as mothers because they used drugs (Mowbray et al., 1995). Another study showed mothers suffering other chronic illness were more likely to report difficulties related to be a parent (Korneluk & Lee, 1998). Interestingly, in the current study, opiate users showed reduced levels of feeling disappointed about the child, feelings of rejection or alienation by the child, and perceiving parent–child interactions as more satisfying. To the best of our knowledge, no previous study, at least in Israel, has examined the effects of opiate use on mother–child interaction.

The relationship between substance abuse and suicidal behavior has been explored by a number of researchers (Bukstein et al., 1993; Dhossche, Meloukheia, & Chakravorty, 2000; Felts, Chernier, & Barnes, 1992). Findings show substance abuse linked to impaired judgment and suicide risk (Bukstein et al., 1993). In the current study, substance-abusing mothers with high levels of suicidal behavior had high levels of anxiety. Furthermore, these mothers reported increased stress about their parental role, disappointment of their children, rejection or alienation by the child, and/or perceived parent–child interactions as not satisfying. These findings are consistent with those of other studies showing anxiety as a suicide predictor among substance abusers (Demirbas, Celik, İlhan, & Doğan, 2003; Khan, Leventhal, Khan, & Brown, 2002).

In sum, substance-abusing women in treatment tend to be at high risk of poverty, mental health problems, and having their child placed in out-of-home care (Holmila, Raitasalo, & Kosola, 2013). Children who do live in homes where a parent abuses substances are at high risk for developing emotional, social, and behavioral problems (Fals-Stewart, Fincham, & Kelley, 2004). Previous studies have found that women entering substance abuse treatment, in contrast to men, are more likely to report the effects of their substance use on their children and family and seek help that includes family services (Straussner & Zelvin, 1997). Therefore, treatment agency personnel should have an awareness and ability to respond to prevailing needs that include parenting skills training that can improve mother and child functioning (Fals-Stewart et al., 2004).

The present study is typical of many studies of drug using women in terms of the difficulty to access a large enough study cohort to justify generalization of findings. This factor limited the nature and scope of the study analysis. Future studies are called for to better understand the parenting among high-risk mothers and fathers especially including those with chronic illness other than substance use such as diabetes, heart disease, obesity, or respiratory disease.

6.5 Future Directions

Despite the nature of this study focusing on women, it is not uncommon to find that most parenting interventions for substance abuse do focus on mothers with children under the age of 5 years (Arria, Mericle, Meyers, & Winters, 2012). The study discussed above and this fact from the literature beg for the development, implementation, and evaluation of interventions that include both parents. It has also been noted that integrated programs (i.e. programs that offered child-related services with substance abuse treatment programming) are associated with improvements in child development, growth, and emotional and behavioral functioning (Niccols et al., 2012). Furthermore, when parents are treated together in evidence-based treatment interventions, the programming can reduce the child's aggressive behavior and other behavioral issues and lead to an overall increase in social competence or ability to navigate the social environment more successfully while deterring early substance use/abuse in the child (Hawkins et al., 1988; Webster-Stratton, 2001).

Another important area of future work, as pointed out by Arria et al. (2012), is focusing on the importance of including both partners in treatment and giving women a voice in the overall addiction treatment experience. These researchers found that a high relapse rate can be a result of low recovery capital that includes self-awareness, stress-coping strategies, and other types of social resources as identified by Granfield and Cloud (1999). If these areas can be bolstered, it can promote the woman's ability toward long-term recovery (Arria et al., 2012).

Finally, with the influx of FSU females, it has been reported that significant differences in background characteristics exist among FSU and Israeli origin women in drug abuse treatment (Isralowitz, 2003; Isralowitz & Bar Hamburger, 2002; Isralowitz & Borkin, 2002; Isralowitz & Reznik, 2009). FSU females tend to be younger than their Israeli counterparts and are less likely to be Jewish. This lack of Jewish identity affects access to government benefits to these women. Also, the FSU women are more likely to be married, better prepared for work through specialized training, and employed than their Israeli counterparts. Interestingly, both the immigrant and native-born women report similar rates of being victims of sexual and physical abuse; this needs to be attended to in any future programming. While both women demonstrate patterns of increased substance use, alcohol and opiate use are higher among FSU women, and Israeli-born women use more cocaine and sedatives. With respect to treatment, FSU women tend to want shorter forms of treatment programming such as detoxification, and FSU women have a greater concern about their personal health and maintaining custody of their children than their Israeli counterparts (Isralowitz, 2003; Isralowitz & Bar Hamburger, 2002; Isralowitz & Borkin, 2002). The cultural variations are critical to consider for the development of treatment programs for these Middle Eastern women, their families, and children.

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Chapter 7
Cigarette Smoking Among Youth: A Regional Health Problem

Richard Isralowitz, Mohammed Afifi, Alexander Reznik, and Steve Sussman

7.1 Introduction

Tobacco contains nicotine, which is a drug, and for which cigarette smoking is its delivery system. Nicotine found in the smoke of cigarettes can, through repeated use, result in addiction. Cigarette smoking allows nicotine to be inhaled through the lungs. For secondary or passive cigarette exposure, the nicotine is absorbed through the mucosal lining of the mouth or nose or through the skin. After inhalation or absorption, nicotine passes rapidly into the arterial bloodstream and then into the brain (Benowitz, 1996).

Tobacco use through cigarette smoking is considered to be the most important preventable cause of death and disease in the world. The substance has caused 100 million deaths in the twentieth century, it causes more than 5 million deaths per year, and, if current trends continue, it will cause up to one billion deaths in the twenty-first century; unchecked, tobacco-related deaths will increase to more than 8 million per year by 2030 (WHO, 2011). On average, smokers die 13–14 years earlier than nonsmokers (CDC, 2012a).

R. Isralowitz (✉)
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel
e-mail: richard@bgu.ac.il

M. Afifi
Substance Abuse Research Center, Palestine

A. Reznik
Senior Research Associate, Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben Gurion University, Beer Sheva, Israel

S. Sussman
Department of Preventive Medicine & Psychology, University of Southern California, Los Angeles, California, USA

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According to the World Health Organization, (WHO, 2011), the tobacco epidemic is one of the biggest public health problems the world has ever experienced, and there are over a billion smokers in the world. Nearly 20 % of the world's adult population smokes cigarettes, and half of all smokers will die from smoking (Proctor, 2012). This is one-third of the world's adult population—about 800 million men and 200 million women smoke cigarettes. Nearly 80 % of the world's smokers worldwide are from low- and middle-income countries where the burden of tobacco-related illness and death is heaviest. Tobacco users who die prematurely deprive their families of income, raise the cost of healthcare, and hinder economic development (WHO, 2011). In developed countries, 41 % of men and 21 % of women regularly smoke (Taylor & Bettcher, 2000; WLF/ACA, 2012a).

Over the past decade, 50 million people in the world have been killed as a result of using tobacco. In the United States, tobacco use is responsible for one in five deaths annually (i.e. about 443,000 deaths per year). In the European Union countries, the number is 500,000 deaths per year and about two million deaths in other countries throughout the world with a high proportion coming from people living in the poorest areas (Isralowitz, 2004a; Peto & Lopez, 2001).

The burden of death, disease, and disability caused by the use of tobacco products more than outweighs the economic benefits from their manufacture and sale (WLF/ACA, 2012a). In the United States alone, each year, cigarette smoking costs more than $193 billion (i.e. $97 billion in lost productivity plus $96 billion in healthcare expenditures). Secondhand smoke costs more than $10 billion in healthcare expenditures, morbidity, and mortality (CDC, 2012a, 2012b).

Secondhand smoke exposure kills those people who do not smoke. The smoke from someone using tobacco contains higher concentrations of cancer-causing carcinogens than mainstream smoke. Breathing second hand smoke causes harm to the cardiovascular and respiratory systems, and it can cause lung cancer. Expectant mothers, fetuses, and infants exposed to secondhand smoke are at particularly high risk of adverse health consequences including sudden infant death syndrome (SIDS), respiratory issues, and behavioral and learning problems (CDC, 2014; WLF/ACA, 2012b). In the United States, an estimated 42,000 of these smoking-related deaths are the result of secondhand smoke exposure (CDC, 2015a, 2015b).

7.2 Adolescent Tobacco Use

Cigarette smoking among young people is a major public health concern. Tobacco use is started and established as a behavior primarily during adolescence (Flay, 1993; Pierce & Gilpin, 1995; Sussman, Dent, & Lichtman, 2001). More than 80 % of adult smokers began smoking before 18 years of age. Each day in the United States, approximately 3,800 youth under age 18 smoke their first cigarette, and approximately one-third become daily cigarette smokers (CDC, 2015c). Young people grossly underestimate the addictiveness of nicotine. Of daily smokers who think that they will not smoke in 5 years, nearly 75 % are still smoking in 5–6 years. Even more concerning is that once adolescents develop a regular smoking habit, it

can be as difficult for them to stop as it is for adults (Eckhardt, Woodruff, & Elder, 1994; Elders, Perry, Eriksen, & Giovino, 1994; Ellickson, Tucker, & Klein, 2001; Sussman, Dent, et al., 2001).

Worldwide, 14 % of the youth aged 13–15 smoke and a quarter of all children who do smoke started by age 10. In 1995 a group of 22 international organizations and individuals met at the Rockefeller Foundation's Bellagio Study and Conference Center in Italy to examine the implications of the current global trend in tobacco production and consumption, especially in developing countries, for sustainable development. Regarding children and youth, it was reported that 300 million will eventually be killed by tobacco use based on current smoking patterns.

> According to the American Legacy Foundation (2001), teenage tobacco users are 14 times more likely to use marijuana than their nonsmoking peers. Other effects include: smoking hurts young people's physical fitness in terms of both performance and endurance—even among young people trained in competitive running; smoking by youth can hinder their rate of lung growth and the level of maximum lung function; the resting heart rates of young people are two to three beats per minute faster than nonsmokers; the younger people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine; smoking is associated with poor overall health and a variety of short-term adverse health effects in young people; and it may also be a marker for underlying mental health problems such as depression among adolescents (Arday et al., 1995).

The most common information collected on tobacco use among youth tends to be specific to those in school. Information of this nature is valuable for the identification of trends and attitudes as well as the promotion of prevention measures. Such information, however, does not reflect the extent of smoking among an underserved high-risk population of youth with learning and/or behavioral problems who have been placed in alternative schools, truants, or dropouts (United Nations, 1999). Additional research and smoking cessation intervention for such youth is particularly important because of their high-risk status for drug use and related problem behavior (Lantz et al., 2000; Sussman, Arriaza, & Grigsby, 2014).

Regarding gender status, the gap between smoking rates among boys and girls is not as large as one would expect. Boys are more likely than girls to smoke, but in almost 60 % of countries covered by the Global Youth Tobacco Survey (GYTS), there was no significant difference in smoking rates based on gender status. The factors that increase the risk of girls smoking are broadly similar to those of boys: tobacco industry marketing; easy access to tobacco products; low prices; peer pressure; tobacco use and approval by peers, parents, and siblings; and, the misperception that smoking enhances social popularity. In cultures where women are subjected to unrealistic body-image ideals, girls and young women may initiate smoking or rationalize their addiction in the mistaken belief that smoking assists with weight loss (Isralowitz & Troestler, 1996; WLF/ACA, 2012a, pp. 28–30).

7.2.1 *Israeli and Palestinian Youth: Regional Perspective*

Smoking rates are problematic among Israeli and Palestinian people. According to the World Health Organization, there are high daily smoking rates among Israeli males aged 20–24 (48 %) and 25–34 (49 %) as well as females aged 35–44 (27 %). A 2012 Israel Ministry of Health report states that 20 % of Israel's population (1.5 million people) smokes an average of 20 cigarettes a day (Vertnik & Lozinski, 2012). Among Israeli youth, an estimated 24 % of males and 13 % of female students aged 15–18 smoke (Godeau, Rahav, & Hublet, 2004), and it has been reported that 17 % males and 12 % females aged 13–15 smoke daily (Shafey, Eriksen, Ross, & Mackay, 2009). Among high-risk youth, the last 30-day smoking levels are high (Bar Hamburger, Rahav, Teichman, Gil, & Rosenblum, 2002; Isralowitz, Afifi, & Sussman, 2008; Isralowitz, Reznik, & Sussman, 2009) and research shows that it is highly correlated with problem behavior. For example, findings show 84 % of the youth in residential treatment facilities for drug addiction smoke regularly (last 30 days); 65 % of youth referred to probation services because of delinquent activity smoke regularly; 32 % of youth who dropped out of school and/or who are not working smoke regularly; and, 29 % of youth in alternative schools because of learning difficulties or behavior problems smoke regularly (Isralowitz, 2004b; Isralowitz & Rawson, 2006; Isralowitz & Reznik, 2006). In a study of more than 2,000 youth in Gaza and the West Bank, it has been found that 26 % smoke regularly compared to 17 % reported in 1999 (Afifi & El Sousi, 2006).

7.3 Smoking Cessation: An Evidenced-Based Model in the Middle East

Smoking prevention and cessation is relevant to developed and developing countries, and "the need to expand comprehensive and effective tobacco prevention and control programs is well established" (Campbell et al., 2008; Sussman et al., 2004). Based on a comprehensive review of evidenced-based smoking cessation programs, Project EX was selected to address cigarette smoking among high-risk Palestinian and Israeli adolescents (SAMHSA, 2012).

Project EX, developed by University of Southern California experts, promotes self-management and resilience abilities for youth through motivation, stress and anger management, coping with nicotine withdrawal, avoiding relapse, and use of alternative medicine strategies (e.g., yoga, meditation), imparted in ways found to be enjoyable among US young smokers (Sussman, Lichtman, & Dent, 2001). The intervention was designed to provide youth with eight 40- to 45-min sessions delivered over a 6-week period using engaging and motivating activities such as games and yoga to reduce or stop smoking. As designed, two sessions are delivered per week for the first 2 weeks of the program, followed by one session per week the subsequent 4 weeks, to follow youth through an acute withdrawal period. Youth are provided with accurate information about the social, emotional, environmental, and physiological

consequences of tobacco use. The first four sessions are intended to prepare youth for an attempt at quitting smoking, which should take place between sessions four and six. The remaining sessions are designed to maintain quit status and enhance quit attempts. Project EX "clinics" operate during school hours. Each clinic group can accommodate 8–15 students. At the completion of the program, youth are expected to (1) stop or reduce cigarette smoking and (2) state accurate information about environmental, social physiological, and emotional consequences of tobacco use. An overview of Project EX is available at https://www.crimesolutions.gov/ProgramDetails.aspx?ID=336.

7.4 Regional Youth: "If the Shoe Doesn't Fit—What Then"?

After months of organization development and delay, including war between Israel and Gaza (December, 2008–January 2009), the Israeli and Palestinian project leaders were able to organize their team members for Project EX training. The training, held in Jerusalem, and led by Dr. Sussman, the primary developer of Project EX, involved six Israeli and six Palestinian personnel. The training included materials, discussion, and role playing for the EX sessions.

Soon after the Jerusalem training, the eight-session Project EX model was presented as a trial initiative at a major residential education facility in the Negev region of Israel and selected sites in Gaza and the West Bank. The subjects were high-risk youth aged 12–18 ($n = 122$). The following details reflect pilot study results of Project EX:

1. There is a need to change the number of meetings. In practice, it is difficult to arrange eight sequential meetings because of holidays, pupils' activities, field trips, school events, etc. Such distractions hurt program continuity and regular attendance.
2. A high level of commitment was required from the project guides. It required work prior to each meeting—preparing the meeting; writing small notes; preparing the equipment, food, and drinks; reading additional material about smoking; and reminding the pupils and the staff about the meeting. The required time for guidance of the project is longer than expected. A person with a lower level of commitment will not be able to guide the project in the best way possible. From our experience, not many teachers have this high level of commitment; therefore, we suggest that someone on behalf of the project work with them.
3. Personal conversations with pupils in need of support are a necessity. All pupils who quit smoking need assistance with personal conversations once every 2 weeks and phone call support from a committed person.
4. The pupils did not like the fact that the guides (i.e. EX instructors) read from the booklet. The response for the reading was "Don't you know the material?" The pupil sees reading from a paper as lack of experience. Therefore, guides had to memorize and write guidance notes on small papers.
5. If older students are involved in the project, it should begin very early in the study year. From the moment national exams start, students are less committed

emotionally and cognitively for Project EX training. The time recommended for starting the project is after the religious holidays.
6. We think that a model, guided by someone other than the classroom teacher, should be considered to promote and implement Project EX. We believe that without this approach, teachers will guide the project poorly or not at all.

Key additional comments included that the contract of the participant to quit smoking should be more detailed. Also, the pupils' recruitment needs to be reassessed because pupils that were caught smoking were obligated to participate and other pupils chose to participate—the majority of the pupils were obligated. It was thought that detoxification/withdrawal should begin early on in the project; it's important not to talk too much about smoking damage; the participant's questions should be answered in detail but not to the point of frightening them. Also, it was suggested that program graduate diplomas might be a good idea, so the pupils feel they have been through something significant.

1. The pupils could not relate to the "talk-show" method and asked for other activities (the talk show is not a part of the Israeli and Palestinian cultures).
2. The pupils did not relate to yoga and considered it "uncool." Perhaps stretching exercises will be more interesting for them or exercises from other fields such as breathing exercises and muscles flexing and relaxation (the advantages of these techniques is that they are applicable everywhere).
3. Using a CO2 device might be good to promote understanding of the level of nicotine in the body and also to help understand how much you can decrease the amount.
4. The program does not provide information about smoking withdrawal aids. This was a difficulty for heavy smokers. Some of the smokers asked us about it, and some even addressed doctors independently. It seems the information may be useful to heavy smokers. (NOTE: Project EX does provide information about smoking withdrawal aids. However, very detailed information is not provided).
5. It might be good to exchange the talk-show method with a visual presentation that helps send important messages. The talk show takes longer than the estimated time since it takes time for the pupils to become energized.
6. Mandatory attendance to the sessions is important.
7. When some of the pupils start to try to quit, it is good to dedicate more time in the beginning of the meeting to see how are they doing, how they are feeling, did they have breaking points and how did they overcome them, and also to reinforce them on their efforts.
8. Food and drink increase attendance.
9. It's important to produce summary cards for the guides.
10. A board and a pen are very important in every meeting. To promote understanding of some of the key points and information, it is helpful if they are written.

The Israeli and Palestinian project organizers discussed the trial outcome and concluded that there was a need to rethink the initiative, making it a three-session "brief intervention" using an external trainer rather than "in-school" personnel. Among the

key reasons were scheduling difficulties with participating schools. Eight sessions over 6 weeks required a level of planning and organizations that was not consistent with the prevailing time lines in the region including expected barriers (i.e. holidays, scheduled activities, teacher's lack of readiness to commit to a health intervention, staff turnover, etc.) and unexpected events (e.g., regional hostility including missile attacks and retaliatory air strikes, and/or teacher absence). In May 2010, an announcement was issued to the US project consultant of this US evidenced-based model in a way similar to Apollo 13 (movie version) contacting NASA-"Houston we have a problem." The consultant advised a five-session approach as a minimum. The Israeli and Palestinian project directors insisted that a three-session "brief intervention" was needed. The US consultant provided input to revise the effort and curriculum. He took a primary responsibility to shape the direction of the three-session version and, at the request of the Israeli and Palestinian investigators, utilized a prevention/cessation format (so that smokers would not be identified and get in trouble and nonsmokers would be included). The sessions were modified to include (1) thinking about quitting or not using tobacco in the future: time = 32–40 min; (2) taking action to quit or not use tobacco in the future: time = 57 min; and, (3) staying stopped or maintaining commitment not to use tobacco in the future: time = 40 min.

Evaluation: Did the Intervention Work? War, the death of project personnel, and other obstacles did not prevent the Israeli and Palestinian project organizers from completing this effort—a model of organization and resilience among the project organizers.

7.4.1 Israeli Findings: Summary

There are important limitations in the study design including that absence of a comparison group, so inferences are limited status. Nevertheless, the results are promising. Overall, males and females reported less smoking last month as a result of the intervention: 29.0 % (pre test), 22.7 (posttest), and 15.0 % (post-posttest) ($p < 0.01$) (Fig. 7.1).

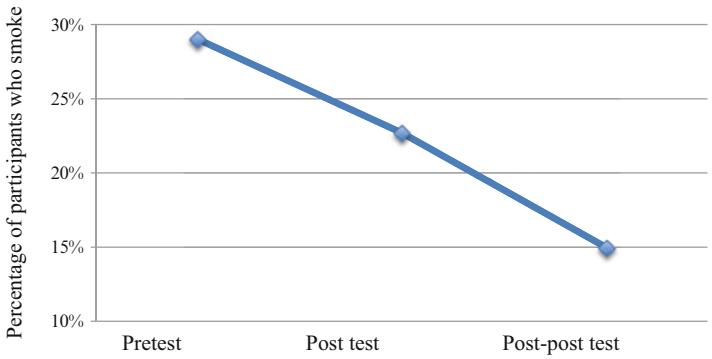

Fig. 7.1 Last month of smoking

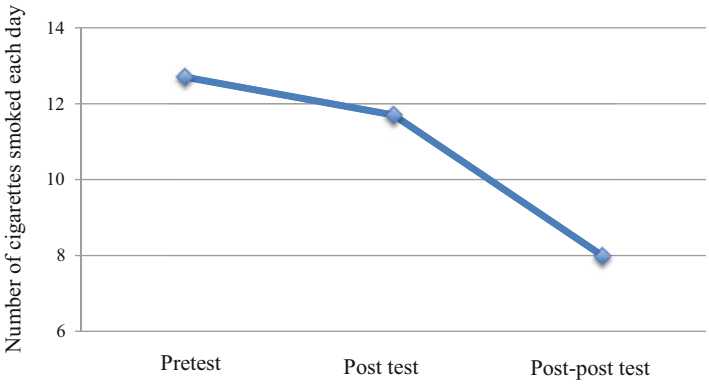

Fig. 7.2 Smoking cigarettes each day (mean): male and female total

Figure 7.2 shows findings from the three-session Project EX brief intervention with secular school male and female students. A significant downward pattern of daily cigarette use was found, including a decrease from nearly 13 to 8 cigarettes each day among non-quitters. It was also found that smoking a cigarette offered from a friend declined from 29 to 21 % and the number of close friends who smoke declined from 79.5 to 59.2 % ($p < 0.001$). Also, religious males reflect a downward trend in cigarette use from 9 to 7 cigarettes each day among non-quitters, a lowering of smoking a cigarette obtained from a friend from 19 to 17 %, and smoking youth tend to have friends who do the same—smoke cigarettes. And, males and females who smoke on a daily basis reported a downward trend in cigarette use–males from 12 to 8 cigarettes each day and females from 13 to 7 cigarettes each day. Females reported they were less likely to smoke a cigarette obtained from a friend from 72 to 60 %. Finally, the responses of "same" students on a before-and-after intervention basis showed that the three-session brief intervention tends to have a positive influence on smoking cessation among male and female, secular and religious students.

7.4.2 Focus Group Assessment

Students ($n = 12$), aged 12–18, who received the brief intervention were asked questions about their perceptions, opinions, beliefs, and attitudes toward the effort. The interview questions, presented by teams of interviewers trained in focus group qualitative interviewing by Dr. Patricia A. Findley of Rutgers University (coeditor of this volume) who visited the Regional Alcohol and Drug Resources Center, Ben-Gurion University, as a Fulbright Scholar, are listed in Fig. 7.3.

Among the significant results from the focus group discussions were: (1) participants felt that the brief intervention needed to be presented by a well-trained professional and not their "in-house" counselors at the high school.

Focus Group Questions

1. What the youth remembered about the Project EX workshops?
2. What makes people quit smoking?
3. What happens after stop smoking?
4. What did the participants take from the workshop?
5. What could be done to follow-up and reinforce non-smoking behavior?
6. What should be changed or done differently?
7. What was most significant for the participant of the Project EX experience? What was positive; what was negative?

Fig. 7.3 Focus group questions

A "more serious" presentation could be given by an outside consultant; (2) evaluation of the experience should be completed soon after the experience since many students forgot the impact of the effort, especially if there is no ongoing smoking cessation follow-up activities; (3) the data collection instrument needed to be shortened, especially if it is going to be used repeatedly over time; (4) redesign or adaptation of the program should be done with youth input, especially those who went through the Project EX experience; and, (5) more attention needs to be given to follow-up and strengthening positive outcomes results from Project EX.

7.4.3 Palestinian Findings: Summary

The smoking cessation project involved a group of school-age Muslim males and females with an average age of 16 years. Among the findings, 23 % males and 7 % females reported lifetime smoking; and, 19 % males and 5 % females reported last month smoking (Figs. 7.4 and 7.5). The average start age of smoking was 11 years for males and 14 years for females. Five percent of the youth smoking in the last month were with one parent compared to 14 % of the nonsmokers. Youth who smoked in the last month were also more likely to spend their time in the evening hanging around (59 %) than nonsmokers (38 %), and 84 % of those smokers had one or more of their parents smoking compared to 65 % of the nonsmokers. Of those same youth, 82 % said they had lectures or classes about smoking hazards, 12 % reported they would accept a cigarette from a friend, and 16 % of the boys and 4 % of the girls believed that smoking boys had more friends than nonsmokers.

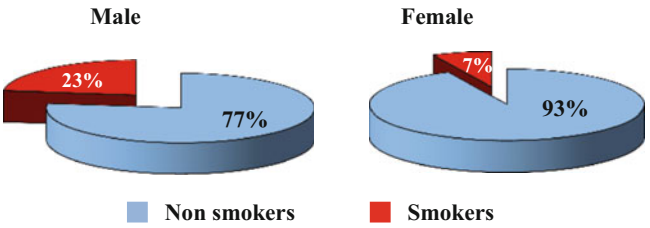

Fig. 7.4 Lifetime cigarette smoking

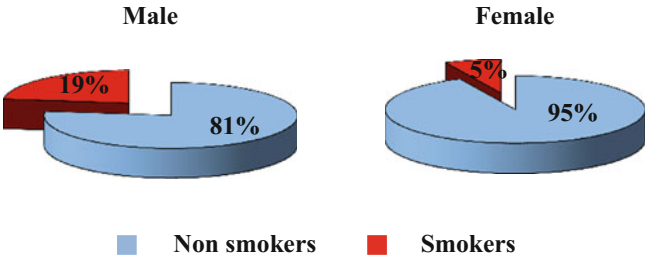

Fig. 7.5 Last month cigarette smoking

Interestingly, 23.3 % of boys and 9.7 % of girls believed that smoking makes boys look more mature. Ninety-one percent of the boys who smoked in the past month and 34 % of the girls have close friends that are smokers with 12 % of the youth reporting that they thought a smoking man is macho and 7 % think a smoking woman is sophisticated. Finally, once addicted to smoking, 89 % of boys and 94 % of girls believe it would be difficult to quit.

7.5 Discussion

This initiative was an extraordinary experience. First, it was a "true" test of the strength of the Palestinian and Israeli project personnel's ability to work together in a spirit of mutual respect and cooperation under adverse conditions to address the needs of high risk youth. This effort overcame war, implementation obstacles, teacher and social worker strikes, the death of a senior project staff member, and the need to revise and adapt the Project EX smoking cessation model as a brief intervention for both Israeli and Palestinian high-risk youth.

Project EX is an evidenced-based program and practice for adolescents that stress motivation, coping skills, and personal commitment. In the United States, it has been implemented/evaluated in numerous sites. Also, it has been implemented and evaluated in countries other than the United States (e.g., China, India, Russia, Spain, Thailand; currently being implemented in Korea). These results led the Israeli and Palestinian investigators to choose it over other interventions to promote smoking

cessation outcomes, cooperation, and knowledge sharing between practitioners and clients. The selection of Project EX was a "conscientious, explicit and judicious use of current evidence in making decisions" (Sackett, Richardson, Rosenberg, & Haynes, 1997, p. 71). However, consistent with the disadvantages of evidence-based programs (Jenson, 2007; Rubin, 2007), it was found early on that the well-defined Project EX curriculum needed modification to respond to Israeli and Palestinian teacher and student learning conditions. Specifically, Project EX was found not to be totally responsive to the culturally unique characteristics/circumstances of both the Israeli and Palestinian teachers and students. It was hard to integrate and implement the initiative with schools due to limitations such as the ability to allocate time for the eight-session intervention. Also, training and supervision was needed for those teaching/leading the intervention as well as other personnel involved, and there was stigma of smoking and denial among students and school personnel. In consultation with others, the project organizers believed the EX problems were manageable by means of various modifications and adaptations.

Consideration was given to qualitative research and modification of the originally conceived project-controlled trials and methodology. These expectations would have been reasonable in a stable environment, but this was not the case because of hostile conditions in the region among other obstacles. In response, a brief intervention approach building on a prospective research methodology was employed in spite of warnings that such an approach may not realize positive results.

Nevertheless, positive, tentatively promising, study results from this initiative were realized, affecting smoking attitudes and behavior among the participants as well as other "useful" information including: the identification of organization and implementation strategies (e.g., using specialized trainers as consultants to schools and youth centers rather than training teachers who may be reluctant and not motivated to take on additional responsibilities that are not remunerated by the school officials); the development of motivation and peer support activities creating a positive health environment and further stigmatizing smoking behavior (an important factor realized especially among Palestinian youth); the large percentage (i.e., nearly half) of the study participants who reported they did not recall school guidance about the dangers of smoking/cigarette use; the large percentage, 48 % of the Israeli and 27 % of the Palestinian youth who spend most of the evening/night hanging around in the streets, malls, playgrounds, and cafés; and, the contribution of a structured learning environment and lifestyle found among the religious students that tends to mitigate smoking attitudes and behavior.

Clearly, greater attention needs to be given to school-based education about the dangers of smoking; and, planned activities need to be made available for youth during nonschool hours especially in the evening/night. This recommendation takes on considerable importance because of the growing number of high-risk youth failing

and dropping out of school. After several years of declining numbers, the Israel Ministry of Education has reported an increase of almost 40 % in school dropouts in 2009, and many of the dropouts come from immigrant and Arab populations. The rate of former Soviet Union origin dropouts, grades 9–12, tends to be about twice the amount reported for youths of Israeli origin (Isralowitz, Reznik, & Straussner, 2011; Leshem & Sicron, 2004). On the Palestinian side, difficult living conditions and stress are factors influencing the increase of smoking among adolescents in spite of the prohibitive attitudes toward tobacco use.

In sum, this joint Middle East effort evidenced a brief intervention that has potential as a cost-efficient and effective smoking cessation model. However, further research is needed to confirm this outcome including its impact on other unfavorable behavior including violence, delinquency, and adolescent alcohol and drug use among Israeli and Palestinian youth.

7.6 Conclusion

Coordinated strategies that address tobacco availability, smoking policy enforcement, and smoking norms can help protect Israeli and Palestinian youth and their communities from the harms of smoking. From this initiative, the project organizers found that a brief intervention implemented by school/community coalitions has potential to reduce students' scores on an index of related consequences of adolescent smoking. The index included items such as attitudes and behavior. Benefits of the brief intervention tend to be school and community-wide affecting not only the smokers themselves but also those around them.

This project contributed to a growing body of evidence suggesting that strategic changes to the environment (e.g., school and surrounding community) can have a positive impact on attitudes and behavior among high risk youth. Using what is known as a school-/community-organizing approach, coalitions comprised of school and community agency administrators, teachers, youth workers, youth, and community leaders may want to consider this brief intervention for possible adaptation and application.

The Israeli and Palestinian project organizers and teams have come to realize that high-risk youth tobacco use and smoking is not just a school problem and it is not just a community problem. Those involved have come to realize that the smoking problem and other problem behavior among high-risk youth must be addressed by entire ecosystems.

Each school and community needs to select and implement specific strategies that address tobacco availability, harm reduction, social norms (i.e., correcting misperceptions about the rate of smoking among peers), and cigarette price/marketing. Several strategies need to be advanced. These include approaches to restrict the provision of cigarettes to underage youth, increase or improve coordination between schools, community youth workers and police (especially in the case of other substance use problem behavior—mostly related to alcohol), and establish consistent dis-

ciplinary actions resulting from policy violations. A systems approach should be considered (Sussman et al., 2012).

For more than 4 years, the Israeli and Palestinian project organizers were involved in this effort to develop, from an evidenced-based eight-session model, a three-session culturally adapted brief intervention addressing adolescent smoking habits and attitudes. Statistically significant decreases were found in cigarette use and attitudes through the brief intervention—enough to warrant further investigation and refinement of the intervention especially for people and places with limited resources dealing with high-risk populations and developing countries. Comparison groups, of course, are needed to understand naturally occurring or standard care cessation rates. Evidenced in focus group interviews of the Israeli participants, the restricted study cohort limits generalization of the current study results. Also, the data collected were based on self-reports of the participating youth who may have underreported (or in some cases over reported) their cigarette use.

From the brief intervention, the percentage of students reporting smoking-related attitudes and behavior decreased. It is particularly noteworthy that the brief intervention has contributed to promoting regional cooperation as well as an intervention that addresses a serious and common health and economic problem affecting the welfare of people throughout the region and elsewhere.

7.7 Future Directions

Finally, an important future step is to focus on methods to promote adoption and implementation of this brief intervention in schools and community agencies throughout the region. This model effort worked to reduce some of the important negative consequences of smoking among Palestinian and Israeli youth; it worked to promote peace in the region through understanding and efforts to address mutual interests and concerns.

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Chapter 8
Immigration, Acculturation, and Drug Use

Alexander Reznik and Richard Isralowitz

8.1 Introduction

Since 1991, with the fall of the Soviet Union and removal of exit barriers, over a million people immigrated from the former Soviet Union (FSU) to Israel. A large proportion of the FSU immigrants had training and education in technical and professional fields (Philippov, 2010). Additionally, there were immigrants who arrived in Israel with drug abuse problems and others became addicted during the absorption process (Isralowitz, Reznik, Spear, Brecht, & Rawson, 2007). FSU immigrants are 11 % of the Israeli population but about 25 % of the estimated 30,000 illicit drug users in the country (Isralowitz et al., 2007). The FSU drug users are mostly from Russia and the Ukraine; others originated from Georgia and the Caucasus region that includes Azerbaijan and the Russian Federation republics of Dagestan, Chechnya, and Ingushetia (see Fig. 8.1). FSU immigrants came from an environment that has poor health indicators and life expectancies caused, in part, from high rates of alcoholism, heroin use, and infectious disease (Hofmann, 2012). Russia, for example, has 2.5 million drug addicts and over 5.1 million drug users; and HIV infection rates are up to 61 % among drug users in some regions of the country linked, in part, to injecting drugs. Both hepatitis B virus (HBV) and hepatitis C virus (HCV) infections are highly prevalent among injection drug users. It is logical to believe there are uniform data about the health issues among FSU immigrants in Israel and other absorbing countries. However, a review of professional literature reveals scant information about drug use, risk behaviors, police reports, and service

A. Reznik
Senior Research Associate, Regional Alcohol and Drug Abuse Research (RADAR) Center, Ben Gurion University, Beer Sheva, Israel

R. Isralowitz (✉)
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel
e-mail: richard@bgu.ac.il

R. Isralowitz, P.A. Findley (eds.), *Mental Health and Addiction Care in the Middle East*, Advances in Mental Health and Addiction,
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Fig. 8.1 Ethnic origins among FSU immigrant drug users

utilization (Guarino, Moore, Marsch, & Florio, 2012; Isralowitz, Straussner, & Rosenblum, 2006). This chapter focuses on acculturation as a factor related to drug use, infectious disease, and health among FSU immigrants who became addicted before or after immigration to Israel.

8.2 Pre-immigration Stage

"Emigration is defined as leaving one's native country, or country of origin, and settling in another. It is related to immigration, but from the perspective of the sending country…. [the action is] based on a variety of motivations including religious, political, and economic" (Loue & Sajatovic, 2012, pp. 598–599). The reasons and motives of immigration may be described in terms of "push-pull" factors. Push factors include unemployment; oppression due to political, religious, or ethnic affiliations; lack of opportunities for personal development, employment, or marriage; and disasters such as floods, earthquakes, fire, war, or epidemics. Pull factors include improved opportunities for employment, higher income, or education, higher environment and living conditions, medical services, and more (Bansal, Taylor, & James, 2005). Additional factors for immigration include personality and psychosocial variables (e.g., behavioral norms, obligations, attitudes, values) that may facilitate or hinder immigration decisions (Moon, 1995). Many norms, attitudes, and values that influence immigration decision-making are reflective of a national

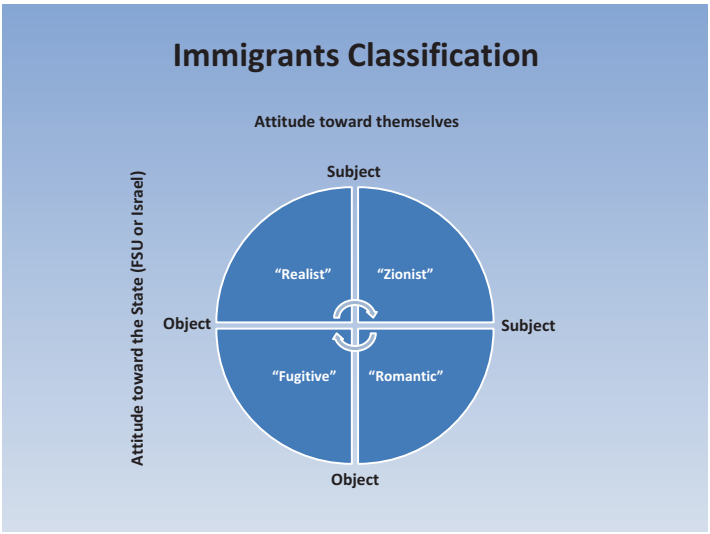

Fig. 8.2 Immigrant classification. Reznik and Isralowitz, modification of figure from Abulkhanova (1997)

mentality (e.g., attitudes toward themselves and attitudes toward country of origin among Russian-speaking people) (Abulkhanova, 1997). This factor, known as "mooring," along with "push-pull" issues makes up a major paradigm of migration research (Bansal et al., 2005). Using the push, pull, mooring (PPM) model, four types of reasoning (i.e. realist, runaway, romantic, and Zionism) help explain why FSU people immigrate to Israel (Reznik & Isralowitz, 2011) (see Fig. 8.2).

Type 1: "Realist." This is a relatively problem-free category of immigrants. Some people of this group had drug or alcohol use problems before their immigration and try to give up their harmful habits understanding its negative impact on their plans to get on with a productive and positive new life. However, difficulties related to interfamily relations or a change of their social status may trigger a return to their harmful behavior.

Type 2: "Runaway." In this case, migrants include those who "failed" in their "home" country or had to "run away" from it for any one of many reasons. Personal attitudes of mistrust and suspicion toward their home country may result in moving on to a new country where addiction problems are better addressed. Consequently, this group tends to include disappointed immigrants who think their immigration was a mistake. They do not bother learning the language of the host, do not look for work; and, do not care about learning a new profession. Over time, the health and well-being of such people deteriorate. Drugs and/or alcohol is used as an escape from the "harsh" realities they face as immigrants.

Type 3: "Romantic." This period before emigration is characterized by romantic and idealized attitudes toward the new country where everything, including personal and social problems, is fine. The new country is associated with opportunities

of education, affluence, treatment of addiction and health problems, and care of the elderly. The host country is viewed in a "paternal, supportive, and caring" context for migrants. When reality sets in and expectations are not met, immigrants of this category may start to use drugs to cope with disappointment.

Type 4: "Zionist." This type of immigrants is characterized by a bonding between self and Israel. Immigration can be explained by ideological or religious motives. "Zionists," who support a nationalist movement of a home land for Jewish people, their culture, and religion, are aware of possible problems and difficulties in the new country but it does not stop them from immigrating.

8.3 Acculturation: Theoretical Perspectives

The term "acculturation" is used to define a set of changes, both at the psychological and social level, which immigrants usually experience in order to facilitate their own settlement to host societies. At the individual level, the term acculturation denotes a complex series of psychological and interpersonal changes that occur when an immigrant experiences a first-hand encounter with a new culture. These encounters may precipitate psychological adaptations (e.g., changes in behaviors and beliefs, identities, values, and attitudes) that are made in order to thrive in the new cultural environment (Encyclopedia of Immigrants Health, 2014, p. 149).

Early models and theories of acculturation saw it as a linear process with immigrants moving unidirectionally from unassimilated to assimilated (i.e. the melting pot). It is now recognized that (a) acculturation is a multidimensional process, (b) complete acculturation requires several generations, and (c) acculturation results are not always positive (Chun, Balls Organista, & Marín, 2003; Unger et al., 2004). Additional views of acculturation reflect the complexity of this process (Alegría et al., 2008; Rudmin, 2003; Schwartz, Unger, Zamboanga, & Szapocznik, 2010) including its planning stages prior to departure, the acculturation process per se, and assessment/evaluation of the adjustment process.

The fourfold theory of acculturation is a popular model contributing to understanding the process (Berry, 1997; Rudmin, 2003). This theory presumes that a person can appreciate, practice, and/or identify with two different cultures (native culture and host culture) independently of one another. As shown in Fig. 8.3, each culture can have a positive or negative influence on a person's attitudes, preferences, attachment, identification, and other conditions that may be evidenced by the presence or absence of certain behaviors, language use, ethnic names, dress, eating habits, and other observable manifestations of culture—their acceptance or rejection (Berry, 1997; Rudmin, 2003).

- Drawing from this theoretical model (Berry, 1997), the four acculturation strategies noted above have been evidenced by alcohol- and drug-using FSU and Ethiopian immigrants to Israel during the last 25 years or so (Fedorova, 2012; Reznik & Isralowitz, 2011; specifically, pp. 117–120).

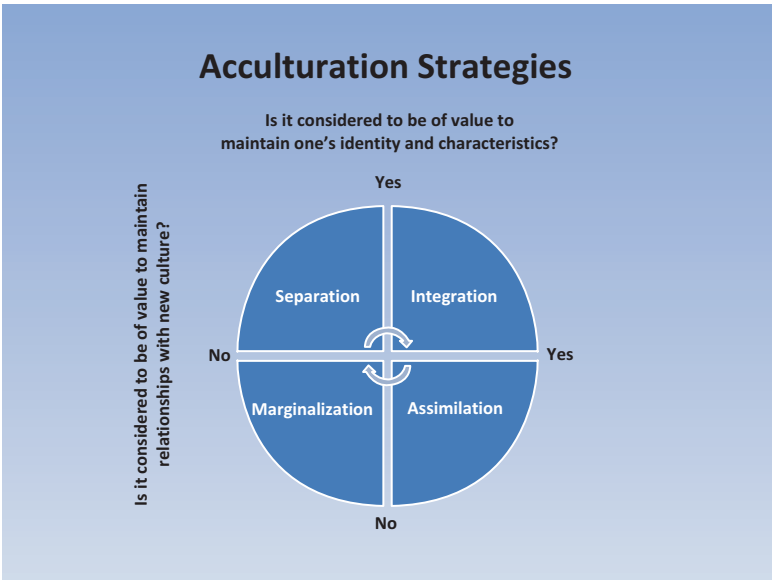

Fig. 8.3 Acculturation strategies. Used with permission from John Wiley and Sons: Berry, J. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*(1), 5–34

- Separation relates to the desire of immigrants to retain their cultural traditions and lifestyles characteristic of their country of origin. They have minimal contact with representatives of a new culture. Such immigrants often aggregate into certain communities of people of a single ethnic origin. Their status in this case is "I am OK but in a country that is alien."
- Marginalization presupposes the renunciation of certain cultural conditions and the inability to adjust to another culture and accept new norms, values, and settings. Marginalization of some immigrants is a serious challenge for many countries. Their personal status is "an alien in an alien country."
- Assimilation presupposes a willingness to overcome cultural distance at the expense of partial or full renunciation of former cultural identity. Immigrants try to quickly learn the language and change their behavior, eating habits, appearance, and more. They start to actively communicate with the host population. Their status in this case is "an alien in their own country."
- Integration includes the ability to retain former cultural identity and acceptance of the new culture. Such immigrants feel quite comfortable in both cultural environments. Their condition can be described as of "being in their own country."

According to Berry (2005), immigrants of the integrated acculturation strategy are least stressed reflecting the ability to access resources and a wide array of coping skills. Those marginalized, on the other hand, tend to be the most stressed. Immigrants in the assimilation and separation groups tend to be somewhere in

between. In a study of Russian-speaking immigrants who came to Israel as children or who were born in Israel to their immigrant parents, most do not feel being Israeli or being from the FSU (Lobich, 2007). A similar situation in Germany has been reported of young migrants from Russia who are seen as high at risk for drug and alcohol addiction as well as criminality (Hoffmann, 2007).

8.4 Immigration, Acculturation, and Meaning of Life

Research shows the meaning of life linked to positive acculturation; it is a protective measure against the pathological behaviors including depression, anxiety, and suicidal tendencies associated with negative acculturation among immigrants (Crumbaugh, Wood, & Wood, 1980; Pan, Fu Keung Wong, Lai Wan Chan, & Joubert, 2008; Wilchek-Aviad, 2014). Also, it is a factor associated with drug use as well as its prevention and treatment (Crumbaugh, 1981; Crumbaugh, Wood, & Wood, 1980; Henrion, 2002; Holmes, 1991; Hutzell, 1984; Koster, 1991; Nicholson et al., 1994; Schulenberg, Hutzell, Nassif, & Rogina, 2008). Marsh, Smith, Piek, and Saunders (2003) found meaninglessness life associated with alcohol (and other drug uses); and it has been linked to cigarette smoking (Konkolÿ Thege, Bachner, Martos, & Kushnir, 2009).

Reflecting on the work of Viktor Frankl (1968), it is possible to gain insight of people caught up in the immigration process—their success, failure, positive understanding of life, or despair (see Fig. 8.4). These conditions can be applied to understanding drug use among immigrants (Fedorova, 2012; Reznik & Isralowitz, 2011).

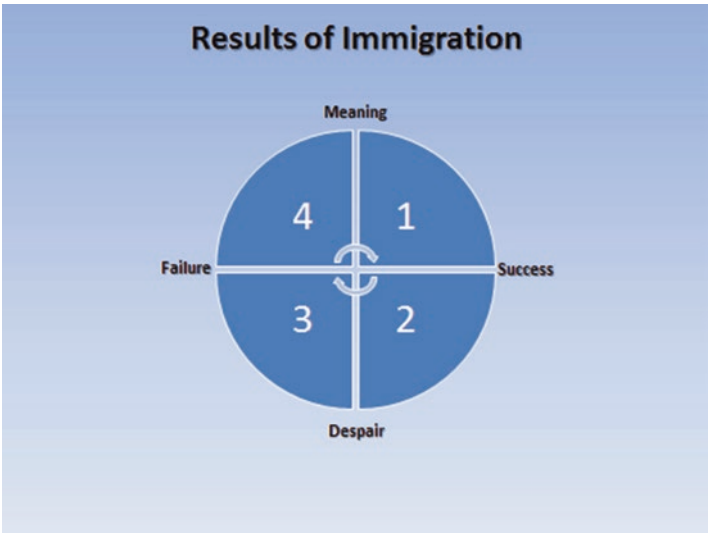

Fig. 8.4 Results of immigration. Used with permission from: Frankl, V (1968). Psychotherapy and Existentialism: Selected Papers on Logotherapy. New York: Washington Square Press, Inc., via Viktor Frankl Book Rights. Langwiesgasse 6, A 1140 Vienna

Zone 1 "Meaning and Success" includes immigrants who successfully adapt to new sociocultural conditions.

Zone 2 "Despair and Success" includes those who achieve something in the new country but have a low level of psychological comfort. They may have lost a sense of meaning about their existence that leads to an "existential vacuum" and possible "noogenic neurosis"—a type of neurosis caused by the loss of meaning (Frankl, 1968). For immigrants from Zone 2, alcohol and/or drug use is often a means to reduce the vacuum and neurosis.

Zone 3 "Failure and Despair" reflects immigrants with collapsed hopes for a dignified future and stable life. Unsuccessful adaptation and loss of meaning in life drive many immigrants to depression and inability to cope with life without the use of drugs and/or alcohol. This group is most in need of social and health services.

Zone 4 "Failure and Meaning" includes people who are ready to overcome difficulties to achieve their goals. Despite the fact that they have not yet achieved success, they can be the winners in any endeavor.

8.5 Immigration as a Multistage Process

Immigration is a multistage process consisting of preparation, acculturation, assessment, and evaluation phases (Reznik & Isralowitz, 2011) (see Fig. 8.5). Based on the discussion above, it may be possible to select appropriate intervention strategies to support immigrant clients providing there is a readiness by the host country to

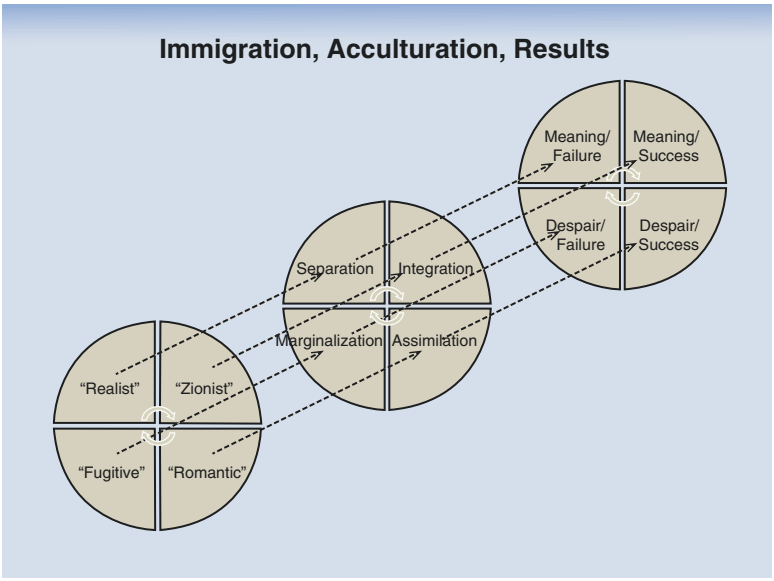

Fig. 8.5 Immigration and acculturation. From Reznik and Isralowitz (2011)

adjust its social institutions to the needs of ethnic groups. Overcoming acculturation stress is not just an individual's problem but rather it is one of all those involved in the general migration process—from the local community and its people to various helping services and organizations.

8.6 Acculturation and Drug Use: A Brief Review

Difficulties with the process of acculturation have been linked to the development of emotional and behavioral problems including mental illness, delinquency, and alcohol and drug abuse (Oetting & Beauvais, 1991; Rogler, Cortes, & Malgady, 1991). Cortes et al. (2003) state that alcohol and drug use emerges as a coping mechanism to mitigate the stresses that immigrants encounter in the host society. This dynamic and highly complex process can lead to personal stress and interpersonal conflicts (Akhtar, 1995; Gaw, 1993; Lu, Lim, & Mezzich, 1995; Sandhu, Portes, & McPhee, 1996). FSU immigrants, regardless of the absorbing country, have faced the challenge of acculturation and there is a lack of information about those who are drug users (Isralowitz, 2002; Isralowitz et al., 2007; Isralowitz & Reznik, 2013).

8.7 Acculturation and Addiction Among FSU Immigrants: A Prospective Study

FSU-born male drug users were surveyed in Israeli treatment centers from 2002 to 2012. Among this study group, 52 % ($n=282$) were addicted before and 48 % ($n=258$) after immigration. The sampling procedure was cross sectional and geared to collecting psychosocial data to estimate drug abuse in the country.

Interviewers made scheduled visits to four treatment sites and invited individuals to participate in the study. The treatment sites included an intake center, a detoxification clinic, a methadone clinic, and a day-treatment facility. These sites represent the types of treatment facilities available throughout the country. Data were collected in a voluntary, anonymous, and confidential manner complying with human subject guidelines of the participating drug treatment facilities and Ben-Gurion University. A staff member responsible for the interview was available to help understand the questions if necessary.

Instruments For this study, all drug use, psychosocial, and health data were based on participants' self-report. The primary data collection tool was the Addiction Severity Index (ASI), 5th Edition (McLellan et al., 1992). Participants were asked to report medical problems including hepatitis C (HCV), HIV/AIDS, and tuberculosis (TB). In Israeli treatment centers, patients are routinely tested for

HCV, HIV/AIDS, and TB and given their results by clinic staff. Other data collection instruments used were adult version of the Substance Survey Instrument (SUSI) that consists of 56 questions about personal background characteristics, substance use patterns, and related problem behavior. Additional measures included questions about age at immigration and time spent in the country; the causes, motives, conditions, and circumstances of emigration; the process of acculturation/adaptation; and, immigration successes and failures including the Short Acculturation Scale (SAS) (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987). These instruments are described by Isralowitz, Affifi, and Resnik (2016). Cronbach alpha reliability scores of the instruments used were ASI (0.71), SUSI (0.88), and SAS (0.91)[1].

8.7.1 Results

8.7.1.1 Pre-immigration Stage

Analysis of interviews showed that the majority of respondents (60 %), in terms of motives, causes, and circumstances of emigration, can be categorized as "fugitives." Causes of flight were dispersed including economic difficulties, threat to life (Chechnya and Transnistria wars), ethnic pogroms and conflicts in Azerbaijan and the Central Asian Republics, and unwillingness to serve in the army and/or problems with police, the courts, and jail.

Those that can be labeled "romantics" made up 30 % of the study respondents including those who moved to Israel in the 1990s thinking this might be their "last chance" to get out before border closes again, better life conditions exist in Israel, there is an opportunity to receive treatment for drug and/or alcohol treatment, an opportunity exists to visit another country without cost, and there is a possibility to participate in a youth educational or vocational program sponsored by the country[2].

A smaller group of the study respondents can be categorized as "realists." As mentioned above, they understand that drug and/or alcohol use can undermine their plans in the new country. However, when faced with difficulties related to family relations or the change of their social status, they could "break" returning to addiction. This was the case for 10 % of the study group 7–8 years after immigration. Not a single person in the study reported immigration to Israel as a "Zionist."

[1] The Substance Use Survey Instrument (SUSI) may be obtained from the Ben-Gurion University Regional Alcohol and Drug Abuse Research (RADAR) Center by contacting Professor Richard Isralowitz at richard@bgu.ac.il. The SUSI is available in English, Hebrew, and Arabic.

[2] This is the most dramatic subgroup. Start of drug use led to immediate dismissal from the program. After dismissal the young man found himself alone in a strange country and did not always have the opportunity (or desire) to return to their country.

8.7.1.2 Acculturation

Among the majority of immigrants interviewed, poor knowledge of Hebrew and the lack of close friends in Israel reflect conditions of marginalization.

The 12-item Short Acculturation Scale (SAS) addresses factors about language use, media, and ethnic social relations. The scale utilizes a 5-point Likert scale. For items assessing language and media preference, the score ranges from "only Russian" (score = 1) to "only Hebrew" (score = 5). For items assessing ethnic social relations, the score ranges from "all FSU immigrants" (score =1) to "all Israeli" (score =5). Total scores range from 1 to 5. An overall average of 2.99 should be used as a bench mark to differentiate the less and more acculturated respondents. In other words, a respondent is less acculturated if the average score is between 1 and 2.99 and more acculturated if the average score is greater than 2.99 (Davis & Engel, 2011). Study results show the overall average of 1.99 (SD = 0.59) for the 12 item SAS. Only 7.5 % of the sample had a rate of acculturation higher than 2.99.

Immigration at an early age and length of time in Israel were linked to higher values of acculturation. Immigration status (i.e. alone or with partner/parents) is associated with the rate of acculturation. Other findings show positive acculturation connected with work status and whether the drug treatment facility has Russian-speaking personnel. Additional analyses show drug use before immigration is the central factor that negatively affects successful immigration among FSU addicts (Isralowitz & Reznik, 2013).

8.8 Discussion and Conclusion

Analyses from interviews and data show the typical FSU addict is male, single (71 %); 32 years old, living in Israel for 18 years with no close friends (65 %); poor health and a chronic disease (76 %); fear, anxiety, and depression (72 %); and having poor knowledge of Hebrew that is not used in everyday life. The average FSU addict has a profession (79 %), but is unemployed or underemployed (57 %) and has spent time in jail/prison (59 %).

Since the mass immigration of Russian-speaking immigrants to Israel beginning in the late 1980s, research has been conducted evidencing the difficulty of leaving behind a familiar language, culture, and community and its connection with increased risk of psychosocial problems, acculturation, risk-taking behavior, and drug use (Isralowitz, 2002; Reznik & Isralowitz, 2011).

Policy and program decision-makers in Israel have talked about the need for special services to Russian-speaking addicts as well as separate services. However, little has been done to address the issue, and over time, there is growing evidence of acculturation and a diminished need for separate services based on group status (i.e. Russian-speaking immigrant drug users) (Isralowitz & Reznik, 2013, 2014; Isralowitz, Reznik, & Pruginin, 2016). Specifically, there is little long-term evidence that separate programs for special populations are superior to mainstream

efforts; but, that does not mean the special needs of immigrant populations, including those related to acculturation, should be ignored (Yehudai, Sarid, Reznik, Findley, & Isralowitz, 2016).

8.9 Future Directions

This chapter points to the need for additional research of the relationship between acculturation and psychological and behavior outcomes associated with drug use. Such research needs to take into account multiple theoretical models of acculturation addressing stress, assimilation, biculturalism, and other factors as a pliable process in which individuals do not necessarily relinquish the values, behaviors, and attitudes prescribed by their culture of origin in order to adopt those of the host culture.

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Part II
Mental Health and Emergency Conditions: Promoting Human Resource Development

Chapter 9
Disaster Relief Mental Health Resources: Community-Based Interventions and Implications for the Middle East

Rachel Alvarez and Patricia A. Findley

9.1 Introduction

A key part of recovery, relief, and rebuilding following a disaster is access to relevant mental health resources. While there is a body of work surrounding evidence-based best practices, there is often a gap between what is theoretically correct and what is utilized in practice. In addition, many resources are focused on mainstream recovery and often neglect outreach to vulnerable populations. Many programs, both economically and socially/emotionally, are also initiated outside of affected communities without direct input from those impacted, this can cause the survivors to become disempowered in the process and become potential bystanders of their own recovery. The purpose of this chapter is trifold to (1) review current disaster relief mental health practices with reference to the Middle East; (2) explore the theories of critical consciousness, international disaster relief, and community-based participatory research; and, (3) apply these three strategies to potential future mental health actions in the recovery, relief, and rebuilding stages following a disaster.

R. Alvarez (✉) • P.A. Findley
School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA
e-mail: Rsalvarez8@gmail.com

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9.2 Disaster Relief Mental Health

Disaster relief mental health practice differs from traditional mental health practice in that emotions are normalized following a crisis in contrast diagnosing and treating typical pathology (McIntyre, 2009). Best practices state that following an immediate crisis, open discussion among peers is encouraged. The sharing of feelings and emotions, incidents that occurred and commiseration of loss, aids in the normalizing of reaction to the crisis (Farberow & Frederick, 1978). Also, this is seen in working with children by encouraging expression of feelings through art or writing, trying to maintain routine, excusing them from some ordinary tasks, addressing both the child's and one's own feelings about the disaster, and encouraging activity (SAMHSA, 2007). By utilizing schools, childcare centers, and other structures, services can be rapidly assessed and delivered to the widest variety of people, including working with vulnerable populations such as the elderly, people with physical and/or psychiatric disabilities, children, and people who are homeless or who are refugees, utilizing the already accessed systems is also crucial. Instead of waiting for people to come to providers, providers need to utilize preexisting system structures.

Mental health resources are considered most beneficial when they are flexible, empowering, compassionate, and respectful (National Biodefense Science Board (NBSB), 2008). Services should address both the individual and community needs in a timely manner. Essential to the implementation of evidence-based practice is the training of responders in post-traumatic stress management. Focus should be on increasing resiliency and decreasing vulnerability to promote proficiency in self-care. While highly trained professionals are crucial to a disaster response, it is equally necessary to utilize grassroots organizations to mobilize in their communities following a disaster as there will not be time or resources to solely rely on mobilizing highly trained professionals (NBSB, 2008). Creating a dialogue with the community instead of merely issuing commands is also highly recommended. Through conversation, practitioners can consistently embrace and work with cultural differences in each community. Working to educate the community on why certain actions are being taken is increasingly important to promote empowerment and remain focused (NBSB, 2008). General consensus among experts in the field is that interventions may not need to be clinical or have a pathological focus, but do need to involve community supports. Crucial elements in the relief and rebuilding stages are creating a sense of safety, calming, sense of self and community efficacy, social support and connectedness, and hope (Hobfoll et al., 2007; McIntyre & Nelson Goff, 2011).

9.3 Coping Practices in the Middle East

Disaster relief has a different character in the Middle East as it usually focuses more on terrorism, particularly in the last 15 years when the Al-Aqsa Intifada erupted in September 2000 (Perliger & Pedahzur, 2015). The media contributed to the extensive and graphic images that were seen in real time and often repeatedly,

contributing to the shared sense of a significant national crisis (Bleich, Gelkopf, Melamed, & Solomon, 2006). Furthermore, it has been noted that very little is known about how to cope with the chronic threat of terrorism (Dickstein et al., 2012). The little research that has been done, particularly on individuals in the Middle East exposed to chronic terrorism, shows that some of these individuals develop post-traumatic stress disorder (PTSD), while others remain resistant with a low level of stress and/or impairment; also, there is another group that can remain resilient and carry on with their lives seemingly "bouncing back" with little impact (Dickstein et al., 2012). Knowing that individuals can be resistant or resilient, Dickstein et al. (2012) felt it was important to understand the factors that bolster this type of response to promote the highest levels of coping possible.

To address the issue of coping and the impact on mental health, Dickstein et al. (2012) gathered data in 2009 on the mental health impacts following conflict, 7 months after the Gaza War of 2008. Structured telephone interviews consisting of 100 questions were conducted of 450 Hebrew- and Russian-speaking residents of Sderot and Otef Aza (bordering the Gaza Strip), who were 18 years and older. Using exploratory factor and moderation analysis, these researchers found that the three coping factors where being used maladaptively: denial, disengagement, and social support seeking were detrimental to psychological functioning. To explain the counterintuitive result of social support being detrimental, the researchers noted that the interviews took place at a point where stressors were still present and, within the context of ongoing trauma, the respondents did not feel that they could adequately help others while trying to help themselves (Dickstein et al., 2012). The one factor that they found that was protective against psychological distress was acceptance and positive reframing (77.1 % of the sample reported using this strategy). This reframing was also associated with lower levels of PTSD, depression, anxiety, and stress. All three of the detrimental factors noted above were associated with increasing these mental health outcomes. The use of acceptance and positive coping was seen by the researchers as a reasonable coping strategy in the face of the uncontrollable nature of chronic stress and terrorism, where problem-focused strategies may be less effective.

It is well documented that risk and resiliency factors impact mental health outcomes in studies conducted in both US and Israeli populations, but the mechanism of how they impact is not yet clear (Hobfoll, Canetti-Nisim, & Johnson, 2006). One theory that has successfully predicted outcomes is the conservation of resources theory (COR), especially in response to war, terrorism, and disaster (Hobfoll, 2012). The COR theory suggests that consequence of stress can emerge from either an actual loss or the threat of loss of physical/material resources or psychosocial resources such as social support. Ironically, in the face of terrorism, the theory suggests that resiliency and continued maintenance of stress resistance resources are needed to confront terrorism, yet these are the exact facets that terrorism threatens. Thus, Hobfoll et al. (2006) argue that because terrorism has a collective nature in how it impacts communities, this leads to increased social support and coping. In their study, Hobfoll et al. (2006) found that of the 905 adult Jewish and Arab citizens of Israel exposed to terrorism, those with greater social support were also less likely to develop depressive symptoms or PTSD. These researchers felt that their findings pointed to the need for secondary prevention of mental health disorders,

suggesting that media and public officials should be communicating messages regarding forms of social support and effective coping that can bolster resiliency rather than just broadcasting messages of fear.

9.4 Crisis Intervention (Relief and Recovery)

Mental health services following an immediate crisis currently come from a variety of sources. Among these are international, national, and regional mental health resources as well as local community organizations (World Health Organization, War Trauma Foundation and World Vision International, 2011). There are currently no set of guidelines on how they are coordinated (NBSB, 2008). However, for the World Health Organization (WHO), emphasis is placed on psychological first aid (PFA) (World Health Organization, War Trauma Foundation and World Vision International, 2011). For example, within the USA, following the 9/11 attacks, the National Institute for Mental Health (NIMH) gathered top professionals in the fields of mental health, trauma, and resiliency to create guidelines on how to most efficiently respond to communities following a disaster (McIntyre & Nelson Goff, 2011). The following operationalized interventions were noted as being essential in immediate response: preparation, planning, education, training, and service provision. This follows an established hierarchy of needs including safety, shelter, food, and medical care; the acceptance of the interventions should be voluntary. Consensus of evidenced-based practices among the NIMH participants concluded that early, brief, and focused psychosocial interventions will reduce distress and that cognitive behavioral approaches will reduce incidence, duration, and severity of PTSD, and depression (NIMH, 2002).

It has been noted that the period of early intervention begins immediately following the disaster and lasts for approximately two weeks (NIMH, 2002). The goals of early intervention are survival, communication, adjustment, assessment, and planning. Expected behavior could move from fight or flight, to resilience and exhaustion, and to grief and narrative. The role of the responder would be to provide PFA (Macy & Solomon, 1995), starting at rescue and moving toward orienting and sensitivity. This would include assessing basic physical comfort and needs, determining immediate, available support systems, and compassionate listening (Macy & Solomon, 2010). The role of the mental health worker would start at the orienting phase and continue to subsequent stages. Activities would include conducting a needs and clinical assessment, performing outreach, fostering resiliency, and being available for consultation, training, and assistance to other agencies or caregivers. Opportunities would be created for social interaction, education about stress and coping skills, and providing group and family support while fostering the natural supports in the community (NIMH, 2002).

Employing PFA reduces painful emotions such as confusion, fear, anger, anxiety, grief, and loss of confidence in addition to reducing further harm. PFA is an eight-stage process. The first step is that of contact and engagement in a non-intrusive, culturally competent manner. Building respectful relationships is the fundamental basis. Second is the establishment of safety and comfort. This addresses the fight or

flight reaction people may face following a disaster. Third is to calm and orient survivors. The goal is not to tell panicked people to calm down, but to be a stable presence in the community. Fourth is to gather information and tailor services to suit each individual and community. The fifth step is that of practical assistance. This includes helping people with decision-making skills and breaking large problems into small, manageable pieces. Sixth is to provide social support by providing consistent contacts with families and communities. There is evidence that mental health states improve after a crisis with consistent social support. Seventh is to provide information on coping and stress reduction to improve efficacy. The last is to provide linkage to collaborative services. By providing these links, survivors will know what options are available for future needs (Macy & Solomon, 2010; McIntyre, 2009).

Furthermore, PFA is a technique that is delivered on a foundation of trust and respect. Variations based on language, culture, religion/spirituality, and history must be taken into consideration. Workers should be present in the community from the beginning to build a foundation of trust. From the beginning, there should be a sense of pulling together and working as a community. If mental health workers are present at this time in the community, they are more likely to be seen as part of this community (McIntyre, 2009).

In addition to PFA, the second model currently being used for disaster relief mental health is the Federal Emergency Management Agency's (FEMA) Crisis Counseling Program (CCP) (FEMA, 2012). CCP normalizes reactions to disaster and helps individuals and communities develop coping skills with the goal of returning to pre-disaster mental health status. CCP assesses strengths to bring hope to communities and aims to assist the return of pre-disaster community conditions. This happens by assessing the needs of a community and identifying if and where a breakdown occurs. The goal of CCP is to support infrastructure until it can be once again maintained by the community. The model utilizes community members of the affected community to provide services, following the concept that people will be more apt to talk to someone they know. CCP responders are not necessarily mental health professionals, but instead, will refer to mental health agencies if a need is identified. Lastly, responders disseminate educational materials about reactions, mitigation, where to find help, and what to expect (McIntyre, 2009).

In an effort to better understand how to reach the more vulnerable populations (e.g., elderly, children, homeless, persons with mental illness), in September 2013, two focus groups of stakeholders (program directors, employees, and volunteers) were conducted to assess the impact of Hurricane Sandy, a disastrous rain storm that hit New York and New Jersey in October 2012, on communities (Findley, Indart, & Kley, 2015). The focus of the groups was on the vulnerable populations in Ocean County, New Jersey, a county in New Jersey that was particularly hard hit by the storm. Observations from those groups included that during this initial phase following disaster, there was a lack of communication and a disruption of services for vulnerable populations. There is no statewide electronic medical list and people who evacuated to shelters may have been left without adequate medication. Some medical doctors and psychiatrists volunteered at shelters but were hesitant to fill prescriptions for psychotropic medication without adequate information. Shelters were also unprepared to take in people with various special needs including

those on respirators, those with phobias, and those on methadone. In addition there was no information provided about those on Megan's list (i.e. a list of individuals convicted of sexually assaulting a child); thus families with children were placed in a vulnerable safety situation. This reiterates the need for mental health program planners to be present at disaster planning and implementation meetings on local, county, state, and federal levels (Focus Group, September 2013). If these plans are in place ahead of time, it was felt that there would have been a more immediate assessment, access, and availability of mental health services.

9.5 Rebuilding (Long-Range Goals)

The rebuilding period begins several weeks following a disaster and lasts for 2–10 years depending on the severity of the disaster (Norris et al., 2002). Also, this is the time period when there may be significant private or governmental funding to organizations and agencies for mental health resources and programs. Following the initial recovery and repair, common mental health issues are adjustment and post-traumatic stress (McIntyre, 2009). Unlike the general consensus achieved by the experts about the relief phase, there is a lack of consensus on best practices about this intermediate stage (Hobfoll et al., 2007). Instead of specific recommended actions, there is a generally recommended framework with the purpose of maintaining flexibility due to the wide range of variables that could come from any disaster (Hobfoll et al., 2007). Included in these variables is how an event affects a community of people. This is illustrated as a line that denotes the difference between a stressful situation and one of trauma. The definition of this line must take into consideration the pre-disaster situation on a case-by-case basis.

Hobfoll et al. (2007) discuss four ways that differentiate between a stressful situation and trauma. First are the physical, social, or psychological effects on the community. This can be as major as seeing bodies floating in the river, people jumping from a burning building, or watching a town disappear. Second would be the devastation of resources especially on a community or group level that is already resource insecure. Also, this can be seen in a middle-income town where grant money is promised to rebuild but has yet to be realized. Third is the loss of attachment bonds, This loss can be seen through violence, forced relocation, or being relocated to another town away from friends and community structures and supports. Lastly, is the assumption of justice, apparent in some cases but, in the absence of such, traumatic in others. When a group of people live a certain way their entire life and then are forced into a situation where they are now dependent on a system that is nonresponsive to their needs, a sense of trauma is created (Hobfoll et al., 2007).

There are five aspects crucial to the framework for this stage of traumatic mental health resources. The first is maintaining a sense of safety. Studies show that those maintaining or reestablishing a sense of safety have lower rates of long-term stress, anxiety, separation anxiety, depression, phobias, and sleep disorders (Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002). To return the sense of safety, there are several interventions that can be used including exposure therapy to restore the balance of

normalcy for regular events. Equally to regain a sense of safety, it is crucial to avoid a pressure-cooker episode where people gather and consistently rehash the traumatic event and fill in unknown details with rumor (Hobfoll et al., 2007).

The second aspect of the framework is to create and maintain a sense of calm. This is essential to normalize and validate people's reactions surrounding the disaster (McIntyre, 2009). When people understand their feelings as normal reactions to crisis, they will be able to move forward. While heightened emotional states are normal behaviors for a week or two following the event, long-lasted heightened emotional levels can be precursors to PTSD. These heightened emotional states can also lead one to overestimate the response to disaster in average events. Consensus for creating a sense of calm is a toolbox approach that includes deep breathing and muscle relaxing techniques, coping skills, role playing, problem solving, and positive thinking. Special attention should be made not to dismiss real worries that follow a traumatic event around economics, housing, employment, or structures (Hobfoll et al., 2007). In addition, a key aspect will be to educate people to use problem solving techniques. These will help break a large problem down into manageable parts (McIntyre, 2009).

Third is a sense of self and community efficacy or the belief that there will be a positive outcome to action with a positive reaction from peers. This is important in several domains including relationships, housing or relocation, employment or retraining, and community structures or rebuilding (Hobfoll et al., 2007). To maintain this efficacy, one must have resources and the purpose and skills to utilize them. For people to believe in themselves, they must possess the skills and tools to move forward. This combination will lead to resiliency and the ability to quickly adjust and handle crisis situations (McIntyre, 2009). Competent communities are those that promote this type of growth in both the individual and family unit (Hobfoll et al., 2007). Communities are collectives of families and when families are strong, communities are strong as well. Competent communities should provide both the resources and education to encourage this type of efficacy among individuals and families. By providing these resources, families will feel that through action, rebuilding is possible (McIntyre, 2009).

Two crucial elements for efficacy are necessary for success. The first is the concept of quick and consistent wins (Hobfoll et al., 2007). This embodies the same concept used earlier in problem solving. By breaking down the large process into smaller, tangible sections, the problems seem less looming and overwhelming. This can also be applied on a community level. By consistently and successfully tackling small projects, both the individual and communities believe they are moving forward and seeing reward for their actions. Projects will increase in difficulty and length over time as the community increases their efficacy. Secondarily, and significantly harder to amend, is the correlation between efficiency and access to resources. According to Hobfoll et al. (2007), research has shown that those who lose the most personal, social, and economic resources during a disaster are apt to be the most devastated. Equally, those who have access to resources to sustain have the best ability to recover. Simply stated, economically wealthier individuals and communities will have an easier time rebuilding than more impoverished neighborhoods and those with more secure support structures will socially and emotionally rebuild quicker and stronger than those without stable relationships and social conditions.

This connection between efficacy and economics is where the line blurs between disaster relief and social service support. Mental health workers should be prepared to focus a significant portion of their work with individuals, families, and communities who, due to lacking both economic and social/emotional resources pre-disaster, find their circumstances exacerbated post-disaster. Hobfoll et al. (2007) recommend mental health programs collaborate with development initiatives to promote better living and working conditions to enhance life choices and chances for better resiliency and life quality. There must be special care taken not to disempower individuals, families, and communities by removing them from the decision-making process. Crucial to this belief of positive outcome is a sense of control (Taylor, 1983).

To illustrate these points, a focus group was conducted in Sea Bright, New Jersey—another very impacted area—8 months after Hurricane Sandy. At this focus group, community members spoke about how they did not have a clear understanding of the information that was available regarding the rebuilding effort. They expressed frustration and a feeling of powerlessness. Many community members were still displaced and spoke of how the town was moving on without them, and they had little access to information because they did not live in the town at present. In addition to losing their homes, they also had lost their sense of community. Many recreational sites had also been destroyed including the recreation building, library, and many cafés and restaurants. There was no central place to gather and reunite with friends. There was no central place to get information in the town about rebuilding, zoning, grants, or procedures. One resident said she felt she had been a victim of the storm and also a victim of false hope and promises. Several community members stated that many agencies (community, governmental, and national organizations) were in Sea Bright immediately following the storm with many promises, but few have come to fruition. Many groups had written for grants and spoken on behalf of Sea Bright, but few had asked what the community members wanted. The process was not driven by the community but instead by organizations working on behalf of the community. This created a sense of further disempowerment and loss of efficacy (Findley, 2013). Although this focus group was held in New Jersey, it may well apply to many other areas following disaster.

Social support and connectedness is the fourth aspect. This connectedness with family and community is important for mental health purposes in this stage. There is evidence that PTSD incidents rise when the family structure is interrupted due to separation (McIntyre, 2009). This may occur due to shelter requirements, relocation in temporary housing, or family members not being geographically present when a disaster happens. To lower the risk to mental health, special attention should be made to reunite families and communities as quickly and sustainably as possible (McIntyre, 2009). Encouraging connectedness promotes problem solving, sharing of experiences, coping strategies, and a general sense of efficacy. Delay in this connectedness is a risk factor for PTSD. Key aspects in fostering social support are enhancing knowledge of types of social support, identifying sources, and learning how to build networks (Norris et al., 2002).

It is relevant to note that in building support networks, care should be placed on promoting individual self-worth. This is necessary to deter dependency on unhealthy

or negative relationships as well as to protect from complacency and overusing supports. For those who have limited natural supports to build on, creating and fostering community supports can also be successful. These can include support groups, welcoming committees, councils, and recreational activities. Specific attention should be taken to protect vulnerable populations from being ostracized or targeted due to lack of resources. Cultural competence is also essential in this period. Culturally diverse and relevant groups should be accessible for traumatic reactions and effects since they are interpreted differently. There has been little systematically examined in relation to vulnerable populations and disaster mental health even though these groups are at a higher risk because of preexisting conditions and socioeconomic struggles. Disaster mental health is focused on the mainstream population with interventions targeted for their needs. Recommended action steps would be to not only train first responders in cultural competence but also to bring at-risk stakeholders to pre-disaster planning meetings and implementation sessions (NBSB, 2008). This can be considered a social justice issue to reduce the level of disproportionality in vulnerable populations in regard to negative outcomes in disaster mental health.

The last aspect of the framework for traumatic mental health resources is instilling and maintaining hope. Hope is often the first victim following a traumatic event. There is evidence that shows that those who maintain hope have less occurrence of PTSD (McIntyre, 2009). The loss of hope is also accompanied by a "shattered world view" (Hobfoll et al., 2007, p. 298). This was seen in the Sea Bright focus group when the belief in the insurance companies and governmental structures was altered (Focus Group, June 2013). People who have been paying for insurance and flood insurance for years found that the companies they had faith in were seeking loopholes to not pay for rebuilding. Equally, a firm belief in the state and federal governmental system to protect and assist had also been shaken when promises for grant funding left many people frustrated. People, who had never sought help from the government, were now asking for help. In addition for having to learn how to navigate through new bureaucracies, they felt embarrassed to ask for help and baffled to be told there was no help available (Focus Group, 2013).

Finally, the focus groups also proposed a list of questions that could be used for a functional assessment of services provided in the first month following a disaster; and many should be addressed prior to a disaster to have the community ready for a quick response. The questions proposed by the group are outlined in Fig. 9.1.

9.6 Role of Social Workers and Other Mental Health Workers in a Disaster

Social workers can be essential in many aspects of a disaster response protocol. Social workers institute research protocols and data collection to examine and reduce adverse conditions. They assess mental or physical health problems, identify high-risk groups, assess immediate health and resource needs, and locate resources.

Community Questions for Emergency Response Preparation

1. Who is providing mental health services?
2. What types of services are being provided?
3. Who is coordinating the services?
4. Why are services being provided?
5. What are best practices for providing services
6. What types of partnerships should be created?
7. What types of partnerships are created?
8. How long is the crisis period?
9. Where services are best provided?
10. What are the vulnerable populations?
11. How are they being identified?
12. How are their needs being met?
13. Who is talking to providers? To administrators? To community members?
14. How are we assessing need?

Fig. 9.1 Community assessment questions for emergency response preparation

In addition, social workers can offer a sound management and community response. This includes creating disaster plans, communication systems, coordinating services, and generating resources that cross the disaster care continuum, from preparation (developing, renewing, and revising a current plan) to the event (supplying resources and support) through recovery and relief (reconstruction, repairing, and healing) (Galambos, 2005). Social workers engaged in direct practice will commonly see responses of fear, anger, and distress. The type of behavior will vary depending on the level of exposure to the disaster situations. Levels include primary (i.e. death of loved one, destruction of property, injured), secondary (i.e. eyewitnesses, rescue workers, those affected by community loss), and tertiary (i.e. overload of media) levels (Galambos, 2005).

Those who were displaced as a result of Hurricane Sandy showed twice as high levels of psychological distress than those who maintained their home (Focus Group, 2013). For those in the focus group, anxiety and panic disorders were more likely among those who were displaced, while adjustment disorders were highest among those who were able to remain in their homes. Recommended to reduce levels of anxiety, panic, and depression among those displaced is to establish a new sense of community, promote control over one's life, and stabilize the social environment.

Three key elements need to be in place prior to a disaster: preparedness of public health emergency rooms, communication among responders, and educational information for the public.

9.7 Community Mental Health

Critical incident stress debriefing (CISD) (Mitchell & Everly, 2001) was developed in the early 1980s as a psychosocial stress debriefing technique to occur for first responders within 72 h of a traumatic incident. The technique began to be utilized as the crisis intervention in communities following a disaster. There was general criticism of CISD as being nonresponsive to the needs of individuals affected by traumatic incidents. This critique led to the creation of psychological first aid (Macy et al., 2004). A further critique of CISD from a community-based perspective is the lack of increasing community-based capacity. This increased delivery necessitated the increase of community-based provider capacity. In addition, the WHO recommends local community-based mental health services as a best practice approach (WHO, 2012).

The Crisis Counselor Program (CCP) attempted to address the need to fill this capacity following Hurricane Katrina (Pribanic, 2009). There was widespread outreach by CCP and free community-based mental health resources; however, vulnerable populations still seemed to fall through the cracks. Even though many people returned to their pre-disaster mental health conditions within 2 years, vulnerable populations seemed to still be lingering in a post-disaster state; 8–10 % of people in a traumatic situation will develop PTSD-like symptoms (Pribanic, 2009).

The cause for many of these problems can be identified as lack of resources. Resources can be defined as both governmental and nonprofit organizational social services or natural community supports. These resources are often lacking due to loss of community and social structure, optimism, and control over one's life. Among those at highest risk are poor people, women, young children, elderly, racial and ethnic minorities, and single parents. Exposure to constant stressors and competition for resources are strong predictors (Pribanic, 2009).

Since its inception, shortly after 1950, disaster management was tied to maintaining social order because officials feared a breakdown following a disaster event. Recent research shows breakdown happens when the crisis period is over and competition over limited resources increases. During the crisis event, people are most altruistic (Pribanic, 2009).

Current social theory focuses on social capital and the importance of social networks, reciprocity, group strength, and interpersonal trust (Patterson, Weil, & Patel, 2010). This theory leads to the creation a working definition of community. According to Patterson et al. (2010), when community is only a group of individuals based on geographic or superficial commonality, they lack both cohesion and ability to act together. This lack of cohesion forces the groups to become reliant on a system to make decisions for them. In contrast, a community structured around

diverse types of civil societies (clubs, churches, organizations) can act as one entity for the greater good. The civil society-type community can be more effective than a removed county, state, or national governing body because these community structures are local, rapid, flexible, and adaptive. These types of communities are also the basis for community-based participatory initiatives since they are action and advocacy oriented and understand the connection and relationship between the community, organizations, and the government (Patterson et al., 2010).

9.8 Community Models of Resiliency

Community resiliency refers to a community's ability to support itself through a crisis. Underserved communities are at a higher risk because of lack of resources (Wells et al., 2013). Most models for resiliency and engagement are top down, but disaster requires a 72 h response time that would require a grassroots approach. This condition requires partnership, communication, and community engagement that can improve access to resources and recovery. Grassroots community-driven models emphasize power sharing among participants with knowledge exchange to support partnerships. An example is the community-partnered participatory research model used in Los Angeles following major earthquakes (Wells et al., 2013). This is a three-stage initiative including vision (planning)/valley (implementation)/victory (dissemination). This model has long-term effects for the post-disaster community because it can be used to develop a pre-disaster program of community engagement.

The methodology starts with a community kickoff conference. The conference includes local volunteer agencies active in a disaster relief (VOAD), emergency response (ER) agencies, local government, community organizations, academic institutions, and community members. During the conference, three questions are asked:

(a) What is your organization doing now to build community disaster resilience?
(b) What challenges do you see in increasing this?
(c) What would make your community more resilient?

The information gathered at the conference is utilized to form three working groups: information and communication, partnerships and social preparedness, and vulnerable populations. Each group would meet bimonthly for 6 months to discuss and develop recommendations for community resiliency interventions. These groups would follow critical consciousness guidelines. A discussion of the use of critical consciousness will be included later in this chapter. Typical ideas discussed in these meetings would be unfamiliarity with emergency protocol, lack of transparency, and leadership responses.

The next step for the community-partnered participatory research model, utilized in Los Angeles, is a community response conference. This conference would take place 6 months after the first and provide an overview of goals, summary of findings, presentations, and open discussions. This leads to a community resiliency plan that

would include proposed action plans, ways of acquiring financial support through possible mini-grants, how to gain staff buy-in for community agencies, where to find resources, how to conduct trainings, and potential ways to outreach. A pilot program toolkit for participating community organizations to implement the community resiliency plan should focus on individuals and families. The last step of the model would be to convene for a final workshop that would review how the plan is working in action (Wells et al., 2013).

Smit and Wandel (2006) created a model to identify risk and vulnerability in a community. In the model, community engagement is highlighted and it is culturally adaptable for present and future conditions. Capacity will be evaluated in collective adaptability, coping capacity and resiliency. The model starts with the cause or current exposures and sensitivities. It then identifies the current adaptive strategies. The next step involves analyzing future needs. These future needs will include both future exposures and sensitivities and future adaptive strategies. The model ends with the adaptation of needs (Smit & Wandel, 2006).

9.8.1 Recommendations for a Community Toolkit

Toolkits are useful to address the key issues described above (Image 3 about here).

Among the major resources of a toolkit are:

1. Individual and family disaster plan, supplies, communication, and next steps
2. Vulnerable populations: how to prepare for kids, animals, disabled, seniors, mental health, and language barriers
3. Community response teams: roles and responsibilities
4. Neighbors: mapping local resources
5. Nonprofits/faith-based/small businesses: disaster planning and survival guide
6. Donating and volunteering: how and to whom to donate and where to volunteer

Training components may include:

1. Psychological first aid: listen, protect, and connect
2. Community mapping: identify strengths and risks and respond to emergencies
3. Engagement strategies
4. Develop leadership
5. Train-the-train modules for responders and community staff

Potential evaluation questions when considering what to include in the kit include (Wells et al., 2013):

1. What are the benefits?
2. What are the processes?
3. What are the barriers?
4. What components are most effective?
5. What are the costs?
6. How do strength and risk factors shape the evaluation?

9.8.2 *Disaster Mental Health Utilizing a Critical Consciousness Modality*

While there are many types of models currently being used for disaster relief mental health, the vast majority still reflect a top-down approach. Disaster response models teach how to work in the community, how to identify early signs of PTSD, and how to maintain self-care, but the current pedagogy does not focus on context of situation, socioeconomic relevance, or cultural competence (West-Olatunji & Goodman, 2011).

Mental health professionals often lack both disaster preparedness skills and cultural competence training, which limit their effectiveness in responding to a disaster (West-Olatunji & Goodman, 2011). Cultural competence is necessary for a macro understanding of the crisis situation, whether it is a natural or a man-made disaster. By utilizing a critical consciousness framework, counselors are able to incorporate this broader understanding and build more authentic relationships (West-Olatunji & Goodman, 2011).

Critical consciousness is a praxis-based philosophy that draws on reflection and action. It requires the trainer to take a co-facilitating role with the student to create a teacher-teacher modality (Freire, 1994). While critical consciousness has primarily been used in education, the same concepts can be applied to social work and mental health practice following a disaster. Freire's problem-posing structure can also be described as a cyclical process of listening, dialogue, and action which can be used in therapeutic group work. Through this praxis of reflection and action, group members are able to see connections between their personal problems and those of others which create a sense of shared purpose and unity (Carroll & Minkler, 2000). What is different in Freire's approach is the removal of practitioner as leader. Instead the practitioner fills the role of co-facilitator on the same teacher-teacher level as everyone else. Freire's model differs from conventional group work in that instead of focusing on the pathology of behaviors and helping people fit into the structures of society, critical consciousness seeks to change the structures of society to fit the people (Carroll & Minkler, 2000).

By following the pedagogy of critical consciousness, the first responder will enter a community not as an outside force that further disempowers the already victimized community, but instead as one who both has trust from the community and trust in the community to build a program that will best suit the needs of the community (Freire, 1994). With training in critical consciousness, the worker is able to gain awareness of the ramifications of potential actions in particular communities. They are able to shed their own preconceived notions of the best programs to create built on biases about the individual communities. Mental health becomes a social justice issue that is enhanced with cultural competence. By engaging in critical thinking, practitioners will be able to significantly collaborate with community members and other practitioners (Goodman & West-Olatunji, 2009).

A proposed seven-step disaster relief critical consciousness model mirrors the previously discussed in the community-based participatory action research model

used in Los Angeles to encourage community response for pre-disaster protocols (Wells et al., 2013). Step one must address the practitioners' biases. This would be considered an awareness stage (Goodman & West-Olatunji, 2009). This stage also pertains to acquiring an understanding of cultural competency. It is necessary to understand one's own cultural biases and the dominant universal biases that shape our cultural perspective before understanding of another's culture can take place (McGoldrick, Giordano, & Garcia-Preto, 2005). Having a strong sense of cultural competence is important in disaster relief as practitioners will be going into culturally diverse areas and spending significant time with vulnerable populations. A lack of cultural awareness may aggravate problems due to the ignorance of the community's cultural norms and potential mistrust based on political and socioeconomic historical problems (West-Olatunji & Goodman, 2011).

The second step is respect and value of the community members' knowledge (Goodman & West-Olatunji, 2009). This is shown in the mutual trust that the practitioner and the community have in each other. The community must trust the practitioner and buy-in to the program. But at the same time, it is absolutely necessary for the practitioner to trust that the community has the competence and worth to become a partner in the process (Freire, 1994). If the practitioner comes with a savior mentality (i.e. believing he or she is there to save the community single-handedly), the process will not be successful because the community members will still be objects in the disaster instead of subjects in their recovery.

Context, specifically of socioeconomic standards, is the next step in the critical consciousness framework (Goodman & West-Olatunji, 2009). It is this step that is often forgotten in post-disaster program planning. Often there is a rush to bring services, including mental health services to a disaster site, and the context of the community is lost. There needs to be time to understand the nature of the disaster, if there had been other disasters in the community before, the demographic make-up of the community, the vulnerable populations, community strengths, and risk factors (Goodman & West-Olatunji, 2009).

The understanding of context will be used in the fourth step. Integration is how knowledge is transformed in guided action (Goodman & West-Olatunji, 2009). The goal is to empower by creating a dialogue with the community to guide them in problem solving. The solution can only be reached with problem solving questions and not through dictating types of practice (Freire, 1994). The community should drive the needs and wants of the types of culturally competent mental health interventions needed for success.

Empowerment is the natural consequence and the next step of this type of intervention (Goodman & West-Olatunji, 2009). By partnering with the community, engaging in dialogue, and understanding the wider socioeconomic implications, the community members are able to move from objects to subjects and masters of their own situation (Freire, 1994). The sixth step is praxis, reflection and action together (Goodman & West-Olatunji, 2009). It is here where the community members are now empowered and has the tools to move forward with their own recovery.

The final step is transformation (Goodman & West-Olatunji, 2009). The community members are able to recover and now possesses the tools to help others in

their recovery as well as face future disasters. The World Bank (n.d.) defines a disaster as a serious disruption in the function of the community, where the community cannot recover with its own resources. This type of critical consciousness process may mitigate the reoccurrence of disaster situations by strengthening communities.

9.9 International Approach

International disaster relief utilizes social capital to rebuild after a disaster to enhance capacity and ensure social development (Mathbor, 2007). The level of social capital is measured by the level of solidarity, social cohesion, social interactions, and social networks. This practice focuses on community comprehension, participation, organization, and control. The basis is to build trusting relationships, mutual understanding, and shared actions to bring individuals, communities, and institutions together for the purpose of generating opportunities and resources in the community following a disaster (Mathbor, 2007). International experience has shown that disaster trauma effects are first felt and responded to by the community. Responses are most effective when enacted by community. Investment in community-based preparedness measures saves lives and property. Local communities know their own strengths and weaknesses and will have the most relevant information. Community focus facilitates the knowledge of vulnerable populations (The World Bank, n.d.).

According to the World Bank, disasters are unresolved problems in development. Disaster Risk Management (DRM) is a systematic approach of using decisions, organization, operational skills, and capacity to institute policies, strategies, and coping skills to lessen the impact of natural or technological disaster. In the risk reduction period, hazards can be managed and reduced by building community resiliency. During the response period, DRM determines what kind of relief is needed and how it is administered. Lastly, in recovery, communities are linked to development agencies with the goal of understanding the pre-disaster struggles. DRM is closely linked with community-driven development (CDD) to transfer the control of development from outside agencies into the hands of the affected communities (The World Bank, n.d.).

The United Nation's (UN) International Strategy for Disaster Reduction (ISDR) is a best practice for developing countries (UNDP, 2004). ISDR is based on the concept that disaster reduction must be a national, institutional policy, have an early warning system, increase safety and resiliency through education, reduce risk factors, and strengthen the ability to respond. The UN's approach calls for local communities to drive the program (UNDP, 2004). Communities must define problems, decide solutions, implement strategies and evaluate results, build linkages between communities and governments, run environmental analysis and scan, incorporate the needs and views of the vulnerable, focus on livelihood security, provide information, education, and communication, and have an accountability system in place.

The World Bank recognizes that top-down practices are insufficient to meet the disaster-related needs of poor and vulnerable people because they are less able to identify community dynamics, perspectives, and needs (The World Bank, n.d.).

World Bank-supported programs have a three-step process to build social capital in underdeveloped communities in all stages of disaster planning and preparation, response, recovery, and relief (Mathbor, 2007). Programs are first designed to bond with communities. This includes using social integration, cohesion, communication, collaboration, fostering leadership qualities, aiding members through recreation, religious and spiritual gatherings, political and institutional affiliation, economic interests, and psychological and social supports. The second step is to build bridges between and among communities by engaging in coalition building. And, the third step is to link communities with financial and public institutions. This is accomplished by assisting in mitigating consequences following a disaster and mobilizing community resources, expertise, professionals, and volunteers.

Crucial to each of these stages is education, transparency, and access to information. The World Bank recommends training volunteers all year to generate leadership and management skills and build solidarity. This helps build trust and to understand all resources in a community. Utilizing local media aids in the community's engagement in public awareness. International social workers are well connected to their community, are familiar with resources, encourage leadership potential, and are well versed on ideas on a micro, mezzo, and macro level (Mathbor, 2007).

The WHO has several core principles for international disaster response (IASC, 2007). These include human rights, community participation, a do-no-harm philosophy, building on available resources, and integrating social systems. Their programs facilitate a four-tiered multilayered support system. This system has a base of basic services and security, followed by community and family supports. Nonspecialized, institutional-based supports follow, with specialized services as the final tier. The vulnerable populations they consider at highest risk are women, children, elderly, extremely poor, refugees, people with past trauma, those with mental illness or with developmental disabilities, who are institutionalized, those with social stigma, and those who might be susceptible to human rights violations.

The goal is to apply this international framework to a domestic disaster response. This can be accomplished by building a community Mental Health and Psychosocial Support (MHPSS) unit of local stakeholders. This unit will coordinate assessment, collect and analyze key information, and make ethical and participatory assessments. These assessments will include those with mental illness, assurance of adequate supply of psychotropic drugs in emergency, use and training of PFA, dissemination of information about available mental health services, ability to work with existing structures, and the involvement in interagency meetings. The MHPSS team will be able to identify resources in local community, engage in community partnership participatory action, support community initiatives, support efforts for those at great risks, provide training, and use advocacy techniques.

9.10 Community Efforts

Keeping the community resilient takes effort on the part of the community as well as participation from the individuals. Advocacy efforts have been discussed as one strategy to bolster community resiliency. Braun-Lewensohn and Sagy (2014) report that there is a variance in how rural versus urban communities cope in times of violence, and in this case, missile strikes in Israel. They found that those living in rural communities were more resilient than those in urban environments, based on the theory of connectedness among individuals and communal resources in smaller environments; these connections and resources helped to reduce anxiety.

Norris, Stevens, Pfefferbaum, Wyche, and Pfefferbaum (2008) state that communities can demonstrate effective functioning and adaptation following disasters. This coping relies on "stress reactions, adaptation, wellness, and resources dynamics" (Norris et al., 2008, p. 127). An example of a way to promote community resiliency is evidenced through a project that brought together researchers and community members from Israel and the United States to develop what psychosocial educational materials could be distributed as both a preventive measure prior to disaster or traumatic events or after the fact to help support recovery. Two of these documents are provided as appendices to this chapter (Appendices 9.1 and 9.2). The complete set of the materials are available in English, Arabic, Hebrew, and Russian at http://www.newpaltz.edu/idmh/resources-/usaid.html. These materials were developed by researchers and clinicians from the State University at New Paltz, Ben Gurion University, and Rutgers University through a grant funded by the United States Agency for International Development West Bank/Gaza to work with partners in the Middle East to develop a series of psychoeducational materials to help residents of Gaza, the West Bank, and Israel to cope with traumatic experiences.

9.11 Conclusion

The natural progression of disaster relief mental health services, over time, moves from a top-down rigid approach to a grassroots community participatory plan for sustainability. Any protocol should encompass a theoretical framework of empowerment as a comprehensive and multidimensional approach. Empowerment theory "promotes social justice and advocacy, addresses the role of social power, normalizes difference and occurs on personal, interpersonal and political levels that encompass power relation" (Garcia, 2009, p. 87). It is an approach to use with immigrants and other disenfranchised people for several reasons. It takes into consideration the social, economic, and political forces that were at play in the choice to immigrate, as well as life in the new environment (Reznik & Isralowitz, 2016). Historical perspectives, race, class, and gender are key. It is an approach based on social justice and advocacy (Garcia, 2009) that is concerned with collective action, political engagement, and creating new ways to help people care for each other (Taylor, 1999).

Action is essential for true empowerment. When people are educated using critical consciousness, they move forward to increase their personal or community power in a way that uplifts themselves and their communities. This includes collective areas of concern, experience, and preference. Group consciousness is the understanding of status and power within the group and within the group's place in society. Self and collective efficacy is the belief that a person or community has the ability to effect change in their lives (Gutierrez, 1995).

The empowerment and structural approach does not omit the importance of the interaction between the person and the environment as the psychodynamic and systems approach often do. The psychodynamic and systems framework focus heavily on the individual and how that individual can adjust and cope with their world. Cultural competence in these approaches is used as a basis of understanding the individual and how they interact with their surroundings, but in a way of acculturating the individual into mainstream society. The empowerment approach meets the individual where he or she is and works with individual strengths to not necessarily change them, but to aid in the understanding of perception; how individuals perceive and how they are perceived. They can then move forward with a new understanding of the society of which they are a part. It is important to note that personal responsibility is not removed in the empowerment theory, but instead encouraged.

The final piece of the community-level intervention is the concept of self and collective efficacy (Gutierrez, 1995). This can be compared to Bisman's concept of belief bonding, where the social worker must believe in the inherent worth of the person and their ability to succeed (Bisman, 1994). Self and collective efficacy though is the person and communities' belief in their ability to affect the desired change (Gutierrez, 1995). It again is the difference between the psychodynamic or systems approach and the empowerment approach, where in the former the change agent must believe in the change and in the latter the person must believe themselves capable of facilitating change. This will begin with the awareness of group identity and continue through small victories of change.

9.12 Future Directions

With a look toward the Middle East, it is important to end this chapter with findings noted by several researchers. Bleich et al. (2006) observed that following 19 months of constant exposure to terrorism, they found indicators in their study of 902 households; extreme levels of psychological disorder did not develop in the majority of those households, which may be related to adaptation and accommodation. However, Bleich et al. 2006 found that after 4 years of constant terrorism, there have been mixed levels of coping, with some groups being disproportionately impacted over others. For example, those with fewer resources, such as the Arab population in their study, those less educated, and immigrants, all demonstrated higher levels of distress. Resilience to stress is an ability of some, yet it is the constant stress, particularly for those with fewer resources that should attract attention for future work.

Appendix 9.1: Coping with Traumatic Experiences

Stressful events are part of life for everyone, but sometimes experiences are so difficult that they cause strong emotional reactions that can take time to recover from. This is true for everybody, no matter how strong they are, so people should not feel ashamed or embarrassed if they're having trouble coping with a bad event. The good news is that most people do feel better as time passes, and there is a lot you can do to help yourself and those you care about to recover more quickly.

Some traumatic experiences happen one time and then they are over. Still, because they are so frightening personally or they cause such serious losses (e.g., loss of a loved one or a home), it is common and natural for people to have intense negative feelings that can last for some time.

Many people in some communities are also exposed to repeated threats or losses and to ongoing uncertainty or fear about when the next event will happen. It is even harder to start to recover when you do not really feel safe—but again, there are steps you can take to help cope with your emotions in a healthy way.

Typical Reactions to Stress and Trauma

Whether you're dealing with a single event or with chronic stress, the following are some common responses people often experience after trauma. Often we do not realize these bad feelings are understandable reactions to the stressful event, so being aware of why we feel the way we do now can reassure us that we will not always feel like this.

Emotional reactions	*Behavioral reactions*
• Sadness	• Avoiding reminders of the event
• Fear	• Sleeping too much or too little
• Guilt or shame	• Eating too much or too little
• Numb	• Inability to relax
• Anger or resentment	• Isolating yourself
• Overwhelmed	• Increased conflict with others
• Irritable	• Working too much
Cognitive reactions	*Physical reactions*
• Forgetfulness	• Jumpiness, easily startled
• Poor concentration	• Too much caffeine, nicotine, alcohol
• Disbelief	• Breathlessness, lightheadedness
• Preoccupied	• Stomach upset
• Poor problem solving	• Muscle tension or pain
• Blaming yourself or others	• Headache
Spiritual reactions	
• Increase or questioning of faith	
• Change in religious practices	
• Struggle with questions about meaning, justice, fairness	

All of these reactions can make you and those around you feel terrible. People who have been through a traumatic experience often are afraid they will feel this way forever, but that is usually not the case.

What Can You Do When Stressful Things Happen?

Sometimes we have the ability to change the source of the stress, but often we do not. Still, even if we do not have much power to change the situation, **we do have power over what we can do to make ourselves feel better.**

Think about what you have done in the past to help yourself during difficult times and whether those actions could help now. Many people find the following to be helpful, **but what is most important is to choose actions that work for you personally. Remember that if you make suggestions to friends and family, what works for them may be very different than what works for you.** Consider:

- Turning to family or friends for support and comfort
- Praying or following spiritual practices
- Taking care of your health by eating well and getting enough sleep and exercise
- Listening to music or doing other calming activities you enjoy
- Getting physical activity
- Helping others in your family or community who experienced the traumatic event

Some actions might make people feel better at first but have a negative effect later on. Try to avoid:

- Eating or smoking too much
- Using alcohol or drugs to dull your feelings
- Isolating yourself from others
- Watching too much television
- Sleeping too much or too little
- Bullying people around you
- Blaming or scapegoating people or groups who were not really responsible for the event

Where Can You Get More Help?

As time passes after a traumatic experience, people usually start to feel better, especially if they are using good coping practices. Still, this can take longer than we expect, especially if the stress is ongoing, and sometimes it is useful to seek out more information or to talk to a trained helper who can provide more support.

These materials are made possible by the American people through the United States Agency for International Development (USAID). The contents of these

materials are the sole responsibility of the Institute for Disaster Mental Health at SUNY New Paltz and do not necessarily reflect the views of USAID or the US government.

Appendix 9.2: Help for the Helpers, Caring for Yourself When Assisting Others

Helping members of your community who have been through a traumatic experience can be very rewarding, but it also can take a toll on you both personally and professionally.

While it is important to recognize the occupational hazards of assisting others (especially regarding working with patents who are trauma survivors), it is also important to remember that through regular self-care practices, the benefits of trauma work can outweigh the potential risks.

How well do you take care of yourself? You can only be a competent helper if you are not stressed out personally, so your commitment to self-care and wellness is actually an ethical and professional responsibility. The following are some ways to make sure you are taking care of yourself so you can continue to take care of others.

Rewards and Risks of Helping

Each helper experiences a unique combination of rewards from this kind of work. These rewards are part of the inner positive factors that motivate us to practice in one of the helping occupations. Among the positive feelings a helper can experience following his/her work are **personal growth and self-awareness, a sense of emotional connection with survivors and the community, and pride in overcoming difficult challenges during times of crisis and chaos.** What is it that keeps YOU

motivated to help those in need? One source of self-care is to be aware of the rewards and satisfactions you receive from this work—and to be conscious of signs that the costs of caring are starting to outweigh those rewards.

Two main occupational hazard helpers should be aware of:

1. The first one is **burnout** or **compassion fatigue** (a term more specific to the helping professions in the field of trauma survivors). Workers continuously overextend their capacity to aid others and become emotionally exhausted by the work. This can limit their ability to be effective helpers, but it can usually be cured by taking a break and practicing effective coping methods like those described below.
2. The second main hazard, referred to as **vicarious traumatization** or **secondary traumatic stress**, can be far more serious. In this case, intense or repeated exposure to clients' stories of traumatic experiences can impact the helper as if he or she suffered the traumatic event personally. This can take a serious emotional toll, changing one's beliefs about fairness, justice, or good and evil in the world. Fortunately good self-care can help prevent this reaction from occurring.

Main risk factors in the helping professions are:

- A large amount of exposure to trauma and bereavement
- The trauma experienced by patents (e.g., injuries, death, or grotesque images or sounds) that are passed on to the helpers
- Working with children who are trauma survivors
- The many chronic (ongoing) stressors at the agency or private level
- Helpers having their own unresolved trauma or grief reactions from current or past losses
- Feeling helpless to assist others or an inability to acknowledge successful interventions (they can be major or minor ones)

In the event of large-scale disasters, or in cases of ongoing exposure to terror attacks, helpers often need to tolerate a great deal of ambiguity and uncertainty. In many cases, you may not know the long-term outcome of contact with those you are trying to help. This can add to professional stress. In such events, try to remember the phrase from Jewish tradition:

> *You are not responsible for finishing up the work,*
> *and you are not free to evade it as well.* (Avot, b, 18)

Warning signs for occupational hazards:

Emotional	Health (somatic)	Behaviors	Workplace
• Anxiety	• Headaches	• Sleep changes	• Avoidance
• Powerlessness	• GI distress	• Irritability	• Tardiness
• Sadness	• Fatigue or exhaustion	• Hypervigilance	• Absenteeism
• Helplessness	• Susceptibility to illness	• Appetite changes	• Lack of motivation or imitative
• Depression	• Muscle aches	• Substance abuse	
• Mood swings			

(continued)

Relationships	Thoughts	Spirituality
• Withdrawal/isolation	• Disorientation	• Loss of purpose
• Decreased intimacy	• Perfectionism	• Anger with your God
• Mistrust	• Problems concentrating	• Loss of faith
• Misplaced anger	• Thoughts of harm	• Questioning meaning/ purpose of life and beliefs
• Overprotectiveness	• Rigidity	• Loss of belief in humanity
	• Regression to rigid, maladaptive thinking, and behaving patterns from your past	

- In addition to the signs listed above, other warning signs include a loss of sense of humor, being unable to balance your personal life and work, and/or thinking you cannot be replaced.
- It is often harder to spot these signs in ourselves than it is for other people to recognize them. Therefore, be sure to listen to colleagues or loved ones who suggest you seem upset and stressed or are not acting like yourself.

Self-Care and Effective Stress Management

Early preparedness can promote your ability to be competent and efficient during emergency situations. It is much more difficult to start using new coping strategies during a disaster or a stressful event, the same way it's very difficult to start learning how to swim when you're drowning. Hence, **effective stress management skills should be developed during routine work situations; this will help and guide you when you encounter emergency situations.** The more profound and comprehensive your preparation is, the easier it will be for you to use it when needed. Moreover, in cases of political instability, there is usually a period of tension buildup. This period is the time for pulling out the emergency preparedness contingency plan. Additionally, identifying effective strategies for self-care will help you quickly overcome the negative effects of being a caregiver in an emergency situation.

Below are a few coping practices that may help during emergency situations:

1. Composing personal encouragement and relaxation mantras (written or by heart) such as "I am a member of a varied and well-founded team that shares responsibility among all the caregivers; I do not carry the whole responsibility by myself."
2. Early preparation of family arrangements while you are away—who brings the children home from school/kindergarten, who takes care of the pets, etc. It is preferable to engage all family members in planning these arrangements, for two reasons. First, it will help them be more prepared for emergencies and less stressed during the events. Second, **knowing the situation at home is being cared for will lower your stress during the emergency.** It will help you to have more inner strength and energy to help others in crisis. Another suggestion is to

draw a simple flow chart of activities for emergency events and to provide copies to family members.

3. Practice self-relaxation techniques—due to the high levels of stress generated in emergency situations, **it is crucial to develop techniques for personal stress relief and relaxation beforehand.** The following link is one option for a guided relaxation and guided imagination technique: http://www.youtube.com/watch?v=f0Nc8339rY0&feature=related.
4. Try to think of (or even to write to) a list of colleagues or friends you can approach in order to share the difficulties of coping in an emergency event. Try to think of people living in different cites/regions so that during emergency situations, they may be able to assist you.

One fundamental component in self-care is effective stress management that requires continuous attention. **Good stress management activities improve the way you feel and allow you to function more effectively.** Ineffective activities (like eating/smoking too much or bullying people around you) might make you feel better temporarily, but they do not help you function well in the long run.

Effective stress reductone activities should be a part of your daily routine, not something you practice once in a while or postpone until you really need it. This means practicing good self-care activities every day—realistic ones that you can meet.

Your first step should be to examine your current coping mechanisms and determine which ones are effective, which are not, and what you might do to further develop the helpful ones.

The following are some strategies that are often recommended, but the most important point is to develop practices you will actually use. **Know what works for you, and when you are stressed, remember to do it.**

• Get sufficient sleep	• Take the time off that you are given
• Take regular breaks	• Balance giving and receiving support
• Exercise	• Draw upon your personal self-care plan
• Eat a balanced diet	• Pay attention to the early warning signs of stress
• Connect with others	• Take into consideration worried remarks from your colleagues, regarding your condition
• Have some time alone	• Balance work, play, and rest
• Limit TV and internet exposure	
• Pray or follow your other usual spiritual practices	
• Take time to contact family members, even if your kids have already grown up and aren't dependent on you	

Some of the strategies listed may not be realistic during an emergency; however, they may be later on. Other strategies might be used from the start. For example, at the very beginning of a response, you should not go home after working and watch television covering the event. You need a break!

While functioning under an emergency condition, feelings of professional isolation can rise due to your deployment far from your organic team or due to the interruption of routine team work. Try to plan in advance ways to share your daily experiences with colleagues. For example—arrange a staff meeting with the team you've been working with throughout the day or find the time to call one of your colleagues from home. This will allow you to give and receive support while increasing your sense of cohesion with your colleagues.

Self-Care Barriers

There are many barriers to self-care and many helpers tend to neglect their own needs while helping others. In emergency situations, there may be a lack of resources, time, or adequate supervision. The needs of clients can seem so great that your needs may seem small by comparison, and if others are suffering, you may feel guilty if you attend to your own needs. It is essential that you accept your own limitations and do not see yourself as unable to be replaced in the relief operation since that can quickly lead to burnout.

Remember: Caring for yourself while helping others does not make you selfish or needy.

The care that helpers provide others can only be as good as the care they provide themselves.

Take care of yourself—You never know when the world will need you. (Rabbi Hillel)

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Chapter 10
Psychological First Aid: A Tool for Mitigating Conflict in the Middle East

Patricia A. Findley, James Halpern, Rebecca Rodriguez, and Karla Vermeulen

10.1 Introduction

Israel has faced intense terrorism ever since it has been a state, within its territory, across the borders, and abroad. Residents of Gaza/West Bank and Israel are exposed to chronic tension and conflict, interspersed with periods of acute terror during outbreaks of violence and war. The residents in this region share a common experience of mistrust, stress and loss, and a need for community-based assistance to cope with that stress rather than allowing it to contribute to an increase in conflict. High rates of probable post-traumatic stress disorder (PTSD) and stress-induced health problems have been well documented among Palestinians (Hobfoll, 2011) and Israeli Jews and Arabs (Besser & Neria, 2012; Gelkopf, Berger, Bleich, & Silver, 2012). Traumatic reactions and post traumatic stress disorder (PTSD) frequently result in hyperarousal, hypervigilance, and increased aggression (Halpern & Tramontin, 2007). After a traumatic event (e.g., violence, war, disaster) or chronic frustrations such as poverty or deprivation, individuals are more likely to be aggressive (Renshaw & Kiddie, 2012). Populations in this region are distressed, depressed, and angry, and as a result many are prone to accepting violence and extreme ideologies as a

P.A. Findley (✉)
School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA
e-mail: pfindley@ssw.rutgers.edu

J. Halpern • R. Rodriguez • K. Vermeulen
Institute for Disaster Mental Health, State University of New York, New Paltz, New York, USA

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means of coping. Additionally, children raised in these environments are likely to absorb and echo the violence and hostility that surrounds them, resulting in a multigenerational transmission of conflict and aggression between nations.

10.2 Psychological First Aid (PFA)

Following traumatic events, some individuals experience negative mental health impacts, such as PTSD, anxiety disorder, and/or major depression. However, others may experience posttraumatic growth and feel a positive reaction that brings strength (Pekevski, 2013). The field of disaster mental health focuses on methods to intervene and support both individuals and communities as they experience and cope with situations that can be extremely painful and disruptive to their lives (Halpern & Tramontin, 2007). The goal is to help the individuals and communities recover from disaster; recovery comes with an understanding of reactions to disaster as well as an understanding of when and how to intervene. Reactions to disaster include those that are categorized as normal, extreme, and prolonged or chronic.

Across these levels of response intensity, following a disaster, survivors may have physical, behavioral, material, social, emotional, and/or spiritual needs. Psychosocial support is key once the physical safety of survivors is ensured. Psychosocial support promotes resilience within individuals and communities to "heal the psychological wounds and rebuild social structures after an emergency or a critical event. It can help change people into active survivors rather than passive victims" (http://www.ifrc.org/en/what-we-do/health/psychosocial-support/). Putting that goal into practice, psychological first aid (PFA) uses these principles of immediate response to reduce the initial distress of the disaster event in order to promote longer-term coping. PFA is much like physical/medical first aid where first aid is provided by trained individuals from the general population whose immediate basic interventions might reduce or prevent the need for follow-up with medical providers (Jacobs & Meyer, 2006). PFA contains a set of helping actions that are aimed at reducing the initial posttraumatic distress and supporting short- and long-term adaptive functioning (Ruzek et al., 2007). PFA assumes that individuals will exhibit a wide range of reactions and emphasizes that most individuals will not develop severe mental health issues or prolonged recovery difficulties. In fact, it has been reported that only 11–15% of survivors of a community-wide disaster would develop PTSD (Young, 2006).

10.3 Themes of Psychological First Aid

According to Sphere (2011) and the Inter-Agency Standing Committee (IASC) (IASC) (2007), PFA describes a humane, supportive response to a fellow human being who is suffering and who may need support. PFA involves the following themes:

- Providing practical care and support, which does not intrude
- Assessing needs and concerns

1. Contact and Engagement
Goal: Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner.

2. Safety and Comfort
Goal: Enhance immediate and ongoing safety, and provide physical and emotional comfort.

3. Stabilization (Provided only if needed)
Goal: Calm and orient emotionally-overwhelmed/distraught survivors.

4. Information Gathering: Current Needs and Concerns
Goal: Identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.

5. Practical Assistance
Goal: Offer practical help to the survivor in addressing immediate needs and concerns.

6. Connection with Social Supports
Goal: Help establish brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources.

7. Information on Coping
Goal: Provide information (about stress reactions and coping) to reduce distress and promote adaptive functioning

8. Linkage with Collaborative Services
Goal: Inform and link survivors with available services needed at the time or in the future.

Fig. 10.1 Steps used in psychological first aid

- Helping people to address basic needs (e.g., food and water, information)
- Listening to people, but not pressuring them to talk
- Comforting people and helping them to feel calm
- Helping people connect to information, services, and social supports
- Protecting people from further harm (WHO, 2011)

PFA uses an evidence-informed approach built upon research on the individual components and by consensus in the field among disaster mental health experts; however, empirical research on the effectiveness of PFA is lacking (Pekevski, 2013). PFA seeks to use compassion and caring by those who intervene to reduce the stress of the response to disaster and promote coping among survivors (WHO, 2011). The techniques and actions are to be delivered in a culturally sensitive and respectful manner (Kantor & Beckert, 2011). As outlined in the Psychological First Aid: Guide for Field Workers (WHO, 2011) and depicted in Fig. 10.1, the core actions of PFA are as follows: *Contact and Engagement*; *Safety and Comfort*; *Stabilization* (provided only if needed); *Information Gathering*: *Current Needs and Concerns*; *Practical Assistance*; *Connection with Social Supports*; *Information on Coping*; and *Linkage with Collaborative Services.* Each of these components encompasses techniques such as listening, comforting, helping people to connect with others, and

providing information and practical support to address basic needs (WHO, 2011). They also reflect the five essential elements Hobfoll et al. (2007) endorse as part of any intervention following immediate and midterm mass trauma, which include promoting *safety*, *connectedness*, *self and collective efficacy*, *calm*, *and hope*; when provided together these elements can assist individuals in their recovery.

While PFA is not necessarily intended to be delivered in a particular order, each of the core actions of PFA often build upon the earlier action. For example, *Contact and Engagement* is the starting point of the interaction with the survivor. This action involves the basics of the worker introducing himself or herself and developing a working relationship with the survivors. This relationship is the foundation for the rest of the work to follow. This contact can be initiated by the survivor or by the worker. If it is initiated by the worker, then a compassionate and nonintrusive approach should be used. With this foundation, the worker is able to address the second core action of addressing *Safety and Comfort* with a goal to enhance immediate and ongoing safety, as well as to provide physical and emotional comfort for the survivor. Areas of focus in this step include decreasing any potential harm to the individual by removing them from debris or seeking a medical provider, if necessary. It is important to provide information on disaster and recovery at this point to empower individuals to help themselves as they best can (consistent with Hobfoll et al.'s (2007) emphasis on building self and collective efficacy). This information can assist in reorienting and comforting both children and families (National Center for Child Traumatic Stress Network and National Center for PTSD, 2006). During this phase workers may also be trying to locate missing family members and providing support with grief and spiritual issues, perhaps related to death and identification of bodies.

Stabilization is the next action item in PFA; however, it is only provided if necessary. This is important since PFA is built upon the notion that most individuals will recover without intervention if the individual is only provided with supportive contact (WHO, 2011). Stabilization involves extremely overwhelmed individuals, those who might be unresponsive or exhibiting extreme physical reactions such as shaking, hyperventilating, or crying uncontrollably for a long period of time or those who begin to engage in risky behavior. Addressing these extreme reactions to the disaster takes patience and compassion. Deep breathing, having the worker talk calmly to "ground" the survivor (WHO, 2011), or even medication or professional intervention are all components to be considered in this action item.

The next action items, *Information Gathering*: *Current Needs and Concerns* and *Practical Assistance*, focus on assessment of current needs in the context of the individual's available resources and assistance with the provision of aid for immediate demands. This process of informal assessment seeks to identify the need for immediate referral and additional services. It has been well noted in the literature that it is important that the helper does not ask in-depth questions about the trauma experience as it may provoke additional stress and risk retraumatization of the survivor (Raphael & Meldrum, 1995). Survivors may want to talk about their experiences; however, they should not be pressed for details.

In the phase of information gathering, the assessment is not formal, nor is to provide a diagnosis. The goal is to clarify needs including physical, medical, and

emotional needs, disconnection from family, and to identify prior emotional and physical/medical needs that may provide context for the current concerns. The worker should conduct this assessment in a sensitive way, particularly with children, the elderly, and others with vulnerabilities.

Once the needs and concerns are identified, then practical assistance can be offered. The survivor may require help to clarify the exact need before an action plan to address the need can be put into place (National Center for Child Traumatic Stress Network and National Center for PTSD, 2006). This may be especially true for children and families as they are trying to recover as a family with competing priorities for need and care (Gordon, Farberow, & Maida, 2013). Follow-through by the worker on the action steps identified with the survivor/family is key to ensure the action has been completed (National Center for Child Traumatic Stress Network and National Center for PTSD, 2006); reconnection with social networks has been shown to be an important task following a disaster to bolster overall recovery (Kaniasty, 2012). Helping survivors understand the value of social support, and, in turn, learning how to be supportive to others, is an important action. There is substantial evidence that perceived social support is a significant buffer to stress, even if the support comes exclusively from one reliable person (Norris et al., 2002). If possible, survivors should be physically reunited with loved ones who can provide information, practical support (e.g., help with chores), as well as emotional support and security. Helpers should ask directly "Who might you contact who could help you at this time?" As with the other action areas, special attention is needed for children, the elderly, or others, such as those with disabilities, who might need additional assistance to make or reconnect with social supports.

The final two action areas of PFA are *Information on Coping* and *Linkage with Collaborative Services.* These two actions are focused on emotional responses and less on the concrete services and needs that characterize the earlier phases of PFA. The information shared at this point involves both strategies to promote coping (e.g., stress management, suggestions to help with sleep, and ways to manage a healthy diet with limited resources) and education on *maladaptive coping* (e.g., anger management, or warnings about potential overuse of substances to cope) (National Center for Child Traumatic Stress Network and National Center for PTSD, 2006).

These collaborative services, such as mental health or medical health-care providers, can continue to help the individual to cope currently and over time.

The World Health Organization (2011) also points out that in this phase of PFA, it is important to focus on the developmental stages for children and adolescents to support coping by acknowledging that some regression to earlier stages is not uncommon (e.g., a child who was previously toilet-trained begins to bed-wet) and the child will regain forward developmental strides with reassurance and support. Figure 10.2 depicts some of the developmental milestones/events that children,

Examples of Developmental Milestones/Events	
Age	
0-4 years	• becoming toilet trained • entering preschool • riding a tricycle
5-11	• learning to read and do arithmetic • being able to play by rules in a group of children • handling themselves safely in a widening scope of unsupervised time
12-14	• having friends of the opposite sex • pursuing organized extracurricular activities • striving for more independence and activities outside of the home
15-20	• learning to drive • getting a first job • dating • going to college
Adults	• starting or changing a job or career • getting engaged or married • having a child/having children leave home
Families	• having a child • death of a grandparent or other older family member • moving into a new home
All Ages	• graduations • birthdays • weddings • holidays

Fig. 10.2 Developmental milestones

adolescents, adults, and families may encounter that may be impacted at time of a disaster. The National Center for Child Traumatic Stress Network and National Center for PTSD (2006) asserts that the loss of developmental opportunities or achievements caused by a disaster can be perceived as a significant loss. This possible loss should be attended to using some of the basic principles of PFA communication techniques including listening, comforting, and helping, and through this the helper can link with collaborative services, as needed.

10.4 The Project on Psychological First Aid

This USAID-funded project provided the foundation to assist the most vulnerable individuals (i.e. children, those with disabilities, the elderly) in the Middle East through a train-the-trainer program in PFA, with emphasis on conflict mitigation skills. The modified PFA model that was developed and delivered by the Institute for Disaster Mental Health emphasized that stress and trauma can lead to increased conflict because when stressed we cannot (1) be fully aware of our own feelings, (2) really know what we need, (3) communicate our own needs clearly, (4) accurately

read another person's nonverbal communication, and (5) hear what someone is really saying. This version of PFA also provided direct psychoeducation on how to mitigate stress and conflict by encouraging survivors to:

- Manage their stress and stay calm.
- Pay attention to the feeling of others. Try to recognize and respond to the things that matter to the other person.
- Control their emotions and behavior.
- Try not to hold onto resentments and anger.
- Be aware of and respectful of differences.

The first stage of the project brought together mental health professionals from Gaza, the West Bank, East Jerusalem, and Israel for a 3-day workshop and training event at the Dead Sea in Israel. The location was selected as it was distant enough from other sites to avoid distraction and was experienced as a safe space by all attendees.

The goal of the meeting was multifold. First, together as an international group, in a train-the-trainer format, we sought to teach the principles and practices of PFA to encourage understanding of the impact of disaster and trauma on the different cultures, thereby increasing conflict mitigation. The meetings included cooperative exercises and role-plays that fostered understanding of one another. Second, we provided opportunities for pedagogical instruction in how to train others in PFA, as well as organizational guidance on how to reach appropriate trainees in each community. This train-the-trainer model multiplied the impact of the project, allowing each direct participant to extend their expertise to their wider community. Third, in separate groups, we translated and adapted the PFA materials from English into Hebrew and Arabic for culturally sensitive and relevant use in the communities-at-large. Finally, to carry out the final phase of the project, we instructed the participants on how to now take their training materials and skills to their home communities. Materials and data tracking forms were given to the participants in both paper and electronic formats to allow assessment of these community-based sessions.

10.4.1 Participants

The participants at the international train-the-trainer meeting included mental health professionals such as psychiatrists, social workers, psychologists, community health workers, and social service agency personnel. There were also several graduate students from health- and mental health-related professions. There were 16 participants from Arab communities including the West Bank, Gaza, and East Jerusalem, 15 from Israel (Some of the participants were from the Bedouin communities), and 5 participants from the United States. The principal investigators and lead collaborators, representing three different organizations based in Gaza, Israel, and the United States, coordinated the workshops.

10.4.2 Methods

The train-the-trainer sessions for the PFA materials were held in a large group format with all of the participants. The English version was taught to the group as a foundation that would then lead to the translation and adaptation of the materials in later meetings. The large group sessions allowed time for the materials to be presented and discussed, with time for questions. The room was set up in conference style with round tables; the Palestinian and Israeli participants were mixed at the tables to encourage cross-cultural conversation regarding the different components. Following the train-the-trainer component, opportunity to practice was provided. The participants each took turns at practicing teaching portions of the PFA materials. Facilitators provided feedback and encouragement to those practicing to enhance their skills.

The following day, the participants were divided into Hebrew speakers and Arabic speakers. The tasks for each group were to ensure that the translation of the PFA materials accurately reflected the intent of the PFA language and to adapt the materials to address any necessary cultural variations. Overall, the groups both made extensive, but not significant, changes to the language used; most changes were grammatical or semantic. The groups worked through the materials trying to envision how they would work "on the ground" to ensure the translations and cultural adaptations were realistic and meaningful.

Finally, the groups were instructed on how they were to take what they learned in the train-the-trainer sessions and go back into their home communities to apply their new knowledge of PFA, using the translated and culturally adapted materials.

As the final program component, using their training and the modified PFA materials, participants each conducted PFA trainings in their home settings, teaching groups of community members how to practice PFA in order to support themselves and others in times of stress and conflict. Before the trainings began, community learners/participants were given a pretest assessment, followed by a posttest assessment afterward to assess changes in their level of understanding of disaster, crisis, and the emotional response to crisis. The assessment items were developed by a committee to measure knowledge of training content and changes in perceptions. The full survey is included in Fig. 10.3.

10.4.3 Translation and Adaptation of PFA Materials

The translation and adaption of the teaching materials through small group review and discussion found the cultural response to disaster and trauma to hold the most striking insight for participants and organizers. The Hebrew-speaking group overlaid a perspective on the training that shifted the English-language/American-cultural perspective of the original materials from a focus on empowerment and calming of the individual to one that allowed more open ventilation of feelings using language that was much more direct. This expression of emotion was not

Psychological First Aid Community Training: Pre and Post-Test

Where are you taking this training? _____

How old are you?_____ Are you a man or a woman?_____

Do you have children? _____ If so, how old are they?_____

1. How well do you understand how *different kinds* of crises or emergencies affect people?
   1 2 3 4 5
   (not well) (very well)

2. How well do you understand which groups or individuals may need more help during or after a crisis or emergency situation?
   1 2 3 4 5
   (not well) (very well)

3. How well can you recognize if someone needs help after a stressful time?
   1 2 3 4 5
   (not well) (very well)

4. How well do you understand how to take care of yourself after assisting in an emergency?
   1 2 3 4 5
   (not well) (very well)

5. How well do you know how to assist your neighbor in or after a crisis situation?
   1 2 3 4 5
   (not well) (very well)

6. How well do you understand how ways lowering stress can reduce conflict?
   1 2 3 4 5
   (not well) (very well)

7. How well do you understand ways to assist children, adolescents and those with vulnerabilities?
   1 2 3 4 5
   (not well) (very well)

8. When you are stressed and unhappy, how likely are you to blame/ be angry with others?
   1 2 3 4 5
   (not likely) (very likely)

9. When you are stressed or unhappy how likely are you to look for ways to make you feel less stressed?
   1 2 3 4 5
   (not likely) (very likely)

10. During or after a crisis, how aware are you of and respectful of differences between you and other people?
    1 2 3 4 5
    (not aware) (very aware)

11. How likely do you think training in Psychological First Aid (how to deal with stress) can help to reduce blame or conflict in your community?
    1 2 3 4 5
    (won't help) (will help)

Fig. 10.3 Psychological first aid community training: pre- and posttest

intended to be dysfunctional, rather it was felt that it would be more "normal" to be overtly emotionally reactive and that is what should be supported rather than the message to "relax" or "calm down" first. Once that phase of the more open emotional reaction ended, then the rest of the aid could be administered. At the end of the adaptation session, the Hebrew speakers were very satisfied with their changes to the training materials and felt that they were much more reflective of the Israeli culture and fit the speakers' perspectives more appropriately.

The Arabic-speaking group took a different perspective in how they adapted the materials. There was consensus that terminologies used in the translation were accurate. However, one concern was on the maintaining of confidentiality for the individual while providing PFA due to cultural issues. For example, an impacted Palestinian person will likely be accompanied by close family members and close friends for the first few days following the event. The group put a lot of emphasis on the important role of family members and friends during crisis. Helping survivors connect with family, friends, and spiritual/religious leaders' during crisis are considered to be of high importance. This group also discussed how using positive coping skills is becoming a challenge in this society due to the overuse of painkillers by traumatized persons. Painkillers are easily available at pharmacies without a doctor's prescription. Tobacco smoking is also on the rise. Because of the prohibition of alcohol and drug use under Islamic law, most may deny their use and rarely talk about personal issues outside the family.

All of the final materials incorporating the groups' adaptations are currently available on the website of the principal partner on the grant, the Institute of Disaster Mental Health (IDMH) at the State University of New York at New Paltz: http://www.newpaltz.edu/idmh/usaid.html.

10.4.4 Assessment of Training on Understanding and Response to Crisis

Using the modified PFA training materials, trainers went into the community to educate residents about how to implement PFA principles to assist their families and neighbors in times of conflict or disaster. In the West Bank, 371 (173 males and 198 females) were trained; the average age of the participant was 17.68 years with a range of 14–49 years. In Gaza, 116 (59 males and 57 females) were trained; the average age of the participant was 22.28 years with a range of 16–62 years. In Israel 183 (54 males and 128 females) were trained; the average age of the participants was 32.19 years with a range of 14–70 years. The majority of the trainings in the West Bank were delivered in schools (52 %), while 45 % of the trainings in Israel and 31 % of the trainings in Gaza happened in schools (the remainder in Gaza were predominately in social service agencies). Organizers were particularly pleased at this success in providing young people with productive coping skills as they may be more prone to reacting aggressively in response to acute conflict or chronic stressors.

The 670 individuals who participated in the community train-the-trainer sessions were surveyed using a pre- and posttest design to assess level of understanding of disaster, crisis, and the emotional response to crisis. The following are the results of that assessment by individual question. In each case, pre- and posttest responses for each nationality were compared using a paired samples *t*-test to check for statistically significant change resulting from the PFA training session.

1. How well do you understand how different kinds of crises or emergencies affect people?

Palestinian participants scored an average pretest score of 2.86 and an average posttest score of 3.90, a change which was statistically significant, $t(486) = -16.243$, $p < 0.000$. Israeli participants scored an average pretest score of 3.63 and an average posttest score of 4.15, also statistically significant, $t(104) = -6.190$, $p < 0.000$. As a result of this training, both Palestinian and Israeli participants reported a greater increase in understanding how disaster and emergency situations affect people.

2. How well do you understand which groups or individuals may need more help during or after a crisis or emergency situation?

Palestinian participants had an average pretest score of 3.00 and an average posttest score of 3.99, while Israeli participants had an average pretest score of 3.62 and an average posttest score of 4.17. Both changes were statistically significant ($t(486) = -14.133$, $p < 0.000$ for Palestinians and $t(105) = -7.985$, $p < 0.000$ for Israelis). Again, both groups reported a greater increase in understanding how to identify high-risk individuals groups that need more help during and after a disaster or emergency situation.

3. How well can you recognize if someone needs help after a stressful time?

Both groups also demonstrated significantly significant increases in this area. Palestinian participants average scores increased from 3.37 to 3.99 ($t(486) = -9.177$, $p < 0.000$) while Israeli averages rose from 3.60 to 4.01.

4. How well do you understand how to take care of yourself after assisting in an emergency?

Understanding in the area also improved significantly for both groups. Palestinians' average scores rose from 3.40 to 3.98 ($t(486) = -8.699$, $p < 0.000$) and Israelis' average scores grew from 3.05 to 3.80 ($t(105) = -8.059$, $p < 0.000$).

5. How well do you know how to assist your neighbor in or after a crisis situation?

Once again, the improvement in scores was statistically significant for both groups. Palestinian participants moved from an average pretest score of 3.23 to an average posttest score of 3.99 ($t(486) = -11.579$, $p < 0.000$). Israeli participants averaged 3.01 pretest score and 3.74 posttest, $t(101) = -9.813$, $p < 0.000$.

6. How well do you understand how ways of lowering stress can reduce conflict?

Change in this item was also statistically significant for both groups, with greater improvement among Palestinian participants who moved from an average pretest score of 3.09 to an average of 3.99 ($t(486) = -12.815$, $p < 0.000$), while Israeli participants began with a higher average of 3.32 and ended slightly lower than the Palestinians with a post-training average of 3.93 ($t(101) = -7.157$, $p < 0.000$).

7. How well do you understand ways to assist children, adolescents, and those with vulnerabilities?

Both groups also reported statistically significant improvement in understanding how to assist groups that often have more intense needs in times of disaster. Palestinians' average scores increased from 3.15 to 3.97 ($t(486) = -12.030$, $p < 0.000$) and Israeli averages rose from 3.07 to 3.71 ($t(101) = -8.524$, $p < 0.000$).

8. When you are stressed and unhappy, how likely are you to blame/be angry with others?

Interestingly, this was one topic where neither group demonstrated any significant change as a result of the PFA training, with both remaining stable from pre- to posttest averages. Palestinian participants changed minimally from 2.88 to 2.87 ($t(486) = -0.053$, $p < 0.958$), while Israelis remained exactly level at 3.30 ($t(100) = 0.000$, $p < 0.1.000$).

9. When you are stressed or unhappy how likely are you to look for ways to make you feel less stressed?

Responses to this question returned to reflecting statistically significant improvement for both groups. Average Palestinian scores rose from 3.35 to 3.78 ($t(486) = -6.176$, $p < 0.000$) and Israeli averages went from 3.63 to 3.94 ($t(102) = -5.031$, $p < 0.000$).

10. During or after a crisis, how aware are you of and respectful of differences between you and other people?

Respect for differences also increased significantly and similarly for both groups, growing from 3.47 to 3.93 for Palestinian participants ($t(486) = -7.010$, $p < 0.000$) and from 3.48 to 3.89 for Israelis ($t(102) = -5.477$, $p < 0.000$).

11. How likely do you think training in psychological first aid (how to deal with stress) can help to reduce blame or conflict in your community?

Finally, results for the two groups diverged regarding change in beliefs about PFA's utility in assisting their community, though reported post-training belief levels were very similar. Palestinian participants scored an average pretest score of 3.93 and an average posttest score of 4.33, a statistically significant increase in belief that PFA can help to reduce blame or conflict in their community ($t(486) = -6.385$, $p < 0.000$). Israeli participants' scores did not increase significantly, going from 4.16 to 4.28 ($t(102) = -1.560$, $p < 0.1.22$). While the Israelis' views did not change very much, they began at a higher baseline of belief in PFA. The Palestinians, in contrast, began with less faith in PFA's power to help and concluded the community-based training with even stronger support for it than the Israelis.

10.4.5 Project Summary and Conclusion

This project, Mitigating Conflict Via Early Mental Health Interventions: Community-Based Psychological First Aid Training for Palestinians and Israelis, was intended to address three of the primary goals of USAID assistance for foreign countries: (1) furthering education, (2) assisting societies with preventing and recovering from conflicts, and (3) providing humanitarian assistance in the wake of natural and man-made disasters using PFA as the vehicle to promote communication and cooperation.

As there are significant logistical challenges in bringing Palestinians from Gaza, the West Bank, and East Jerusalem together with Arabic-, Russian-, and Hebrew-speaking Israelis, this cross-border project was ambitious but effective. Results from the train-the-trainer workshop assessment made it clear that the three goals listed above were accomplished. Palestinian and Israeli attitudes toward one another became more positive as a result of the workshop. Both groups furthered their education by learning the principles and practices of PFA, and they worked cooperatively to ensure that all training materials are both linguistically appropriate and culturally adapted to the intended audiences. They also learned pedagogical techniques to effectively teach PFA in their communities. As a result, there are now 30 highly qualified instructors available to not only provide this post-disaster evidence-informed practice themselves but with the skills and resources to train others to deliver PFA throughout their communities. Thus the 3-day workshop helped to reduce conflict, furthered education, and built capacity for effective response to disasters and complex emergencies in the region.

Most workshop attendees were able to deliver the PFA training in their community. The participants in Gaza and the West Bank far exceeded expectations as they trained boys and girls and men and women in a wide range of settings including schools and social service agencies. The Israeli colleagues successfully completed fewer training sessions but they also reached very diverse populations including graduate social work students, nursing students, high school personnel, Arab-speaking students working with the Bedouin population, and personnel providing substance abuse treatment.

Israeli and Palestinian trainers, who returned to their communities with more positive attitudes toward the other, delivered 26 separate PFA training sessions to 670 community members. As a result of these trainings, Israeli and Palestinian community members reported that they better understand how different kinds of crises or emergencies affect people; which groups or individuals may need more help during or after a crisis or emergency situation; how to recognize if someone needs help after a stressful time; how to take care of themselves after assisting in an emergency; how to assist their neighbor in or after a crisis situation; how to assist children, adolescents, and those with vulnerabilities; how to lower stress to avoid or reduce conflict; how to find effective ways to manage stress; and how to be more respectful of differences during or after a crisis. These results suggest the effectiveness of PFA to manage stress and reduce conflict.

Results from two of the items on the pre- and post-training surveys require more discussion. As a result of the PFA training, Israelis and Palestinians did not change their self-assessment on their tendency to blame others. However, their self-rating on this question was not very high at baselines. These participants may have already been predisposed *not* to scapegoat others when stressed. On the last item in the survey, there was a significant difference in the pre- and posttest scores for Palestinians, who were more likely to see PFA reducing blame or conflict in their community after the training. Israeli participant attitudes did not change significantly as the result of the training. However, it is clear that their view of the effectiveness of PFA to manage conflict was already high before the training and the

training confirmed their already positive attitude toward the usefulness of PFA in promoting peace. After the training both groups of community members clearly saw PFA as an effective tool for conflict management and mitigation.

10.5 Future Directions

This is a region that has been severely traumatized with considerable stress, trauma, and loss. Multiple pathways to healing and conflict mitigation are necessary. The project goal was to mitigate suffering and conflict, working from the ground up. Results from both the workshop and community trainings suggest that the trainings may have made some contribution to healing and to peace, though it is difficult at this point to assess the total impact of the project as we do not know how many training sessions will be offered months or even years from now. The PowerPoint slides in English, Hebrew, Arabic, and Russian are available for use for future trainings and there is a well-developed and user-friendly training manual and survey instruments in multiple languages. Current trainers are in a position to deliver many more sessions to additional diverse audiences and we are hopeful that more will be offered. One weakness of this project to date was that workshop participants did not deliver joint trainings. That is, we were not successful in encouraging pairs of Palestinians and Israelis to overcome logistical barriers (such as travel restrictions and language differences) in order to deliver a training together. However, we do hope that this will occur in the future.

It is difficult to imagine working within the Middle East without encountering someone who has endured some type of physical or emotional reaction or trauma related to the ongoing conflicts in the region. While PFA is widely used and is considered an evidence-based intervention, it also requires additional research to understand its impact in the ever-changing environment of trauma and disaster. This program's efforts to build community-level understanding of the principles of PFA and how to apply them is an initial way to build capacity to promote safety, efficacy, and resiliency throughout this troubled region in order to help stabilize residents and assist with coping and rebuilding.

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Chapter 11
Collaborative Approaches to Addressing Mental Health and Addiction Care in the Middle East

Patricia A. Findley

11.1 Introduction

Illicit drug use and trafficking are global issues that are negatively impacting the social, economic, public, and mental health of citizens internationally (Isralowitz et al. 2001; Thomas et al., 2012). Stress resulting from exposure of living in an environment with chronic violence and political unrest can have either a direct and/or indirect impact on an individual's psychological well-being (Thabet, Tawahina, Sarraj, & Vostanis, 2013). In the Middle East, this constant traumatic exposure may lead to serious mental illnesses such as post-traumatic stress disorder (PTSD), depression, anxiety (Thabet et al., 2013), and/or substance abuse (Sweileh, Zyoud, Al-Jabi, & Sawalha, 2014). Furthermore, acculturation is another contributing factor to substance abuse; acculturation can contribute to an increase in alcohol and illicit drug use (Reznik & Isralowitz, 2016; Straussner, 2012). While the focus of this book is on the Middle East, this issue has implications for other regions worldwide dealing with terrorism (Isralowitz, 2002), death (e.g., about a third of European citizens have tried an illicit drug, with overdoses killing at least one individual every hour (European Monitoring Centre for Drugs and Drug Addiction, 2010), and other medical, psychological, and environmental issues (Broyles, Conley, Harding, & Gordon, 2013).

P.A. Findley (✉)
School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA
e-mail: pfindley@ssw.rutgers.edu

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11.2 Collective Trauma

The Middle East has gone through an extended period of trauma related to ongoing conflicts. Reactions to such repeated traumatization can lead to psychosocial reactions, such as drug and alcohol use, that become viewed as normal parts of everyday life (De Jong, 2002). Progler (2010) found that Palestinians continue to live with psychological reactions to the 2008 conflict with Israel, with many individuals experiencing mental health, addiction, and other chronic illnesses. For many in the Middle East, they suffer from historical trauma and transgenerational trauma whereby they refer to the response to chronic stress among whole groups of people and how this stress gets transmitted across generational lines (Firestone, 2014). Firestone (2014) argues that this ongoing sense of trauma and disruption, even from earlier generations, can lead to disempowerment, anxiety, and anger. Such responses can cause individuals to turn toward alcohol and/or other substance abuse.

As with the development of the collective trauma within the community, Somasundaram (1998) found community-based interventions useful in addressing maladaptive reactions for prevention and mental health recovery purposes. The collective level of response allows for community, village, and family rebuilding in which the community itself can be used as a source of support (Somasundaram, 1996). However, some substance abuse treatments, as stated earlier, do respond better to individual interventions such as a 12-step program (i.e. Alcoholics Anonymous and Drug Addicts Anonymous), detoxification, aversion therapy, rehabilitation, and counseling (De Jong, 2002). These will be discussed later in this chapter.

11.3 Substance Abuse Disorders

The advent of the publication of the new Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) in 2013 has collapsed all categories of substance abuse and substance dependence into a sole category called substance use disorders which are measured on a continuum from mild to severe (APA, 2013). The American Psychological Association (APA, 2013) sees this new collapsed diagnostic category as more reflective of what the patient actually experiences. Therefore, throughout this chapter any form of substance abuse condition will be referred to as a substance abuse disorder.

11.3.1 Substance Use: Prevalence and Cultural Meaning in the Middle Eastern Countries

Attitudes and use do vary among the Middle Eastern countries and cultures about the use and abuse of substances. For example, in the Israeli culture, alcohol consumption for religious reasons is allowed; wine in moderation is “praised for

gladness for the hungry heart" (Loewenthal, 2014, p. 973). In fact, drunkenness is condoned on very rare occasions, such as during the festival of Purim, but overall excessive alcohol use is discouraged. Views by the general Jewish and the rabbinical communities on opiate and other mood-altering substance use and abuse have been evolving as concerns over their use have been rising. Drug use is seen as illegal, particularly drugs that are known to be harmful. Under Jewish law "life and health must be protected and the saving of life prioritized" (Loewenthal, 2014, p. 974). Self-control is promoted with rabbinical endorsement of the 12-step programs.

On the other hand, Islam forbids alcohol and substance use, and addictive behaviors are stigmatized within the community- at- large if they are used. However, despite these views, both the World Health Organization and the United Nations Office on Drugs and Crime have found a consistent rising trend in the use of both illicit and licit substances and Arabic countries (UNODC, 2011; WHO, 2011). The most commonly misused substances in the Arab region include alcohol, heroin, and hashish (Al Ghaferi, Osman, Matheson, Wanigaratne, & Bond, 2013).

Attitudes of the professionals can also vary by culture, thus impacting the care of individuals. For example, Lev-Ran, Adler, Nitzan, and Fennig (2013) found in Israel that physicians rated individuals' with alcohol dependence as having "weak character" significantly more than individuals who were dependent on cigarettes or marijuana and individuals who were addicted to heroin as having a "weak character" significantly more than those who were dependent on cigarettes, nicotine, alcohol, or marijuana. This has implications for how the physicians provide care and work with a treatment team.

The World Health Organization has reported wide ranges in the prevalence of smoking among younger individuals (i.e. adolescents and college age) in Arab countries overall (Al-Mohamed & Amin, 2010). For example, the range is lowest at 7 % for Oman, 23 % in Iraq, and as high as 53 % in Yemen. Al-Mohamed and Amin (2010) report from their prevalence study of college students in Saudi Arabia that smoking by parents and siblings was a significant initiator for smoking as well as the continuation of the pattern. They also stated that friends' behavior and attitudes toward smoking played a large role in smoking as well. Surprisingly, Al-Haqwi, Tamim, and Asery (2010) found a 25 % rate of smoking among medical students in Riyadh, Saudi Arabia, despite the fact that 90 % of the students would advise their patients not to smoke and 94 % of the samples reported know that smoking could cause serious illness. Twenty percent of the students felt that smoking had a beneficial effect in stress reduction and used smoking as a coping mechanism.

Both alcohol and illicit drug addiction rates have been on the rise in Israel. Isralowitz and Rawson (2006) report in a study of 911 high-risk adolescents who ranged from 12 to 18 years that girls used cigarettes more than boys, boys used all types of alcohol more than girls, and boys used marijuana and hashish more than girls. This study challenged the societal belief that alcohol and drug use is primarily a male issue in Israel.

More recently, Badr, Taha, and Dee (2014) approximate that the percentage of students using illicit substances by sixth grade has tripled over the last decade in the Middle East. They assert that this is seen in both developed and developing

countries with the cause most likely due to the transition to a more Western society. In their study of 68 adolescents between the ages of 13 and 18 years living in Beirut, Lebanon, and Middle Eastern adolescents residing in California, they found that having an attachment to God was a protective factor for both alcohol and substance abuse in both the Muslim and Christian groups. Similarly, they found a negative relationship between attachment to family and substance use in both groups, regardless of religion or where they lived (Badr et al., 2014). The WHO ATLAS reported that in Saudi Arabia, Egypt, and Jordan, the prevalence estimates of alcohol use disorders among individuals 15 years and older were nonexistent among females, yet among males it was 0.44 (12 month %) in Egypt, 0.38 in Saudi Arabia, and 0.32 in Jordan. Drug use disorders' prevalence was estimated at 1.3 (Egypt), 0.63 (Jordan), and 0.01 (Saudi Arabia) among males. Saudi Arabia found no drug use disorders in females (Sweileh et al., 2014; World Health Organization, 2010). However, the bibliometric analysis (i.e. a statistical analysis of books, articles, or other publications) completed by Sweileh et al., (2014) noted that despite the findings for illicit drugs, most of the published research they reviewed from the Arab countries focused on tobacco smoking and water pipe use.

Gaza has also seen increases in risk-taking behaviors, which include a substantial rise in drug addiction (Isralowitz & Afifi, 2016). Most research points to Tramadol as the drug of choice in Gaza. Despite it being illegal without a prescription, it is easily acquired on the black market or through the use of falsified prescriptions (Progler, 2010). The age of the addicts are between 18 and 30 years old, with many more not presenting for treatment because of the stigma related to mental illness and addiction. Progler (2010) reports that the underlying cause of the increase in substance abuse is related to the ongoing conflict with Israel, particularly after the December 2008 war that left Palestinians "feeling insecure and at risk wherever they are" (Progler, 2010, p. 186).

11.3.2 Substance Abuse Treatment

It is clear that "substance-related disorders are not limited to any particular country or world region" (Sweileh et al., 2014, p. 597). The treatment for substance abuse and co-occurring disorders such a mental illness or every physical illness requires coordination. However, in the Arab countries, much like those in other countries in the Middle East, the ongoing political instabilities and general social and physical insecurities within the country can lead to the creation of psychiatric issues (Sweileh et al., 2014).

Treatment for those with substance use disorders has advanced over the years. It has been found that cognitive behavioral therapy, community reinforcement and contingency management approaches, the 12-step program, family treatment, and motivational therapy are the most effective forms of treatment (Finney, Wilbourne, & Moos, 2007). The underlying value of these treatment strategies is that they focus

Specific Group	Problems	Intervention
1. Children	Learning disorder	Play therapy, art therapy
	Conduct disorder	Family therapy
	Trauma	Referred for child therapy
	Child soldier	Rehabilitation
	Child abuse	
2. Women	Somatization	Find out the social cause
	Anxiety neurosis	Counseling, relaxation
	Depression	Social case work
3. Alcoholics	Chronic alcoholism	AA, Medical therapy
	Acute alcoholism	Detoxification, aversion therapy
4. War victims	PTSD	Medication, rehabilitation, relaxation exercises, counseling
5. Drug Abuse	Addiction	Withdrawal, behaviour therapy & counselling
Neuropsychiatric problems		
1. Children	Epilepsy	Antiepileptic drugs + play therapy
	Mental retardation	Advice to go to school, counselling, referral to ARK
2. Schizophrenia	1. Acute emotional problems	Psychotropic medication, & ECT
	2.Chronic illness	Maintenance medication, observe for side-effects, dose titration, compliance, reduce expressed emotions at home
	3. Social problems	Social case work
	a. Economic	Occupational therapy, employment
	b. Marriage	Marital counselling
	c. Security	Yellow ID card
	d. Social stigma	Mass media propaganda

Fig. 11.1 Common psychosocial problems and interventions (Reproduced from Somasundaram and Jamunanantha (2002), with acknowledgement of the National Institute of Mental Health)

not only on the addictive behavior but also on the context in which the client lives while reinforcing self-efficacy and the promotion of behavior change. Figure 11.1 outlines common psychosocial problems and interventions (Somasundaram & Jamunanantha, 2002).

For individuals with co-occurring substance abuse and psychiatric disorders, their care is much more complex with research data supporting an intensive integrated case management team-based type of model as most effective, particularly since dual diagnosis, based on epidemiological data, should be expected as the norm and not the exception (Minkoff, 2001). In fact, Minkoff (2001) asserts that better outcomes are attached to more systems-level changes which can establish inter-program collaboration.

11.4 Integrated and Collaborative Care

Much attention has been given to develop more integrated (i.e. treatment for mental health in primary care settings) and interprofessional (i.e. simultaneous and collaborative treatment by two or more professionals) care in the past decade. The United Kingdom saw a rise in these types of care models starting in the 1980s (Bailey & Dfapa, 2013) and the stabilization of the models with financial infrastructures coming from the National Health Service and Local Authorities. Other countries have been slow to follow the shift in models, with the latest to join being the United States that received a boost from the implementation of the Patient Protection and Affordable Care Act (P.L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), collectively referred to as the Affordable Care Act (Patient Protection and Affordable Care Act, 2010). Collaborative Care models have been shown to be effective for treating individuals with chronic illnesses as well as mental illnesses (Thota et al., 2012). Collaborative Care models have evolved from Wagner's Chronic Care Model (Wagner, Austin, & Von Korff, 1996). The Collaborative Care model, much like the Chronic Care model, involves multiple levels and specialists in the delivery of care. This approach uses case managers to link primary care providers (i.e. physicians), patients, and mental health specialists with other mental health specialists (i.e. psychiatrists and psychologists) for possible services needed. Thota et al., (2012) found that for mental illness:

> This collaboration is designed to: (1) improve routine screening and diagnosis of depressive disorders; (2) increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders; and (3) improve clinical and community support for active client/patient engagement in treatment goal-setting and self-management. (p. 526)

Working in an interprofessional collaborative manner does take practice as well as self-awareness of one's professional role on the team. Loxely (1997) contends that power and culture are two salient themes that professionals use when they are assimilating into job roles. Varying value systems of different professions can also influence the care provided and the manner in which it is communicated to the patient. For example, a social worker may see the individual suffering from addiction as being caught with an environment where drugs are readily available and part of the culture and seek to shift the individual out of the harmful environment. On the other hand, a psychiatrist may treat the patient with medications and refer for psychotherapy to get at the root of the addictive behavior. Either approach is credible, but if the professionals cannot come together on a decision for a strategy, the patient can become lost at the mercy of the power struggles over perspectives.

The Department of Health in the United Kingdom sets forth 10 Essential Shared Capabilities (ESC) that all staff in their mental health workforce, both professional and paraprofessionals, are required to follow (Brabban, McGonagle, & Brooker, 2006). The intent of the capabilities is to help the disciplines and other key personnel to keep their focus on ideals for the patient while achieving their own occupational standards. These capabilities are to be at the core of mental health practice that supports effective implementation of integrated programming (Brabban et al., 2006). These 10 Essential Shared Capabilities are listed in Fig. 11.2.

The 10 Essential Shared Capabilities	
Working in partnership	**Identifying people's needs and strengths**
Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.	Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.
Respecting diversity	**Providing service user centered care**
Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.	Negotiating achievable and meaningful goals; primarily from the perspective of service users and thier families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is need, including systematically evaluating outcomes and achievements.
Practising ethically	**Making a difference**
Recognizing the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users, carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.	Facilitating access to and delivering the best quality, evidence-based and value-based health and social care interventions to meet the needs and aspirations of service users, their families and carers.
Challenging inequality	**Promoting safety and positive risk taking**
Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in communities they come from.	Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.
Promoting recovery	**Personal development and learning**
Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health system.	Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

Fig. 11.2 The 10 Essential Shared Capabilities (Used with permission from Brabban, A., McGonagle, I., & Brooker, C. (2006). The 10 Essential Shared Capabilities: A framework for mental health practice. *The Journal of Mental Health Training, Education and Practice*, *1*(3), 4–15)

Integrated care models (i.e. the co-location of mental health and medical professionals within primary care settings) have become more prominent in healthcare settings in various parts of the world. It has become an important component of a healthcare delivery system that has better coordination and can be more cost-effective (Kodner & Spreeuwenberg, 2002). Integrated care has been embraced by the World Health Organization Study Group that views the integration as a way to deliver more holistic and individualized care to a patient with multidimensional care needs (WHO, 1996). Thus, integrated care goes beyond just developing an interdisciplinary team, it is delivering mental healthcare that is "consistent with the goals, strategies and culture of primary care" (p. 109)—and not just adding mental health services to primary care, the services need to work in concert with one another (Bailey & Dfapa, 2013). This includes the involvement of the patient's community and all who care for those with addiction and mental health services as well

as a commitment to providing treatment in a way that does not stigmatize them and is holistic in nature that views the mental health and addiction issues as undifferentiated from the patient's physical health (Bailey & Dfapa, 2013). This is critical, when mental illness and a substance use disorder are comorbid (i.e. when two disorders or illnesses occur in the same person, simultaneously or sequentially). Minkoff (2001, p. 598) notes "each disorder should be considered as primary, and integrated dual primary treatment should be provided."

Despite the evidence base for integrated care, Kodner and Spreeuwenberg (2002) argue that sometimes achieving the integrated care goal falls short in many, if not most, countries. The coordination of such multiple services to address mental and physical health in the context of the psychosocial needs can be daunting; the funding and administration of two types of care may be different sources. This is evidenced in work by Courser et al., (2013) agreeing that drug addiction is well documented in Afghanistan, but organized substance abuse treatment has been slow to follow, until very recently. Isralowitz and Reznik (2014) point to a similar issue in Israel where the majority of drug users do not receive care directed at the individual and the society level programming seen as beneficial to enhance overall well-being??. Likewise, a study conducted in Syria only used behavior cessation intervention provided only by physicians that showed poor outcomes with a 16 % cessation rate in the brief intervention arm of the study and 4 % in the intensive arm (Asfar et al., 2008). Thus, despite efforts to support more integrated and collaborative care, that goal is not being realized in the Middle East.

11.5 Conclusion

As stated earlier, Sweileh et al., (2014) made it clear that substance abuse disorders are not limited to a particular region of the world, yet the focus of this chapter has been on the countries in the Middle East. It is evident that much work is needed in the treatment of individuals with substance abuse and/or comorbid mental health issues in those countries. There appears to be consensus on the fact that the treatment needs to be culturally sensitive and relevant offered in a collaborative or integrated manner that will promote evidence-based practice (Hafeiz, 1995; Isralowitz & Reznik, 2014; Nakash, Razon, & Levav, 2015; Shawahin & Çiftçi, 2012).

11.6 Future Directions

Prevention programming is an area of emphasis for the mental health community of psychological practitioners in Israel. However, the education of other professionals including medical students is limited in mental health prevention. In fact, Nakash et al., (2015) point out that a significant amount of the available resources for mental health services is directed toward treatment or rehabilitation rather than prevention.

These researchers feel that the most important action steps include creating partnerships with relevant stakeholders, capacity building and training to develop expertise in prevention programming for those with mental health issues, program development, and the actual delivery of care in a collaborative team/public health model rather than individualized care.

Sweileh et al. (2014) argue that the Arab countries should invest in more international collaboration to heighten the visibility of substance abuse among its people for policy makers and international agencies. Isralowitz et al., (2001) concur on the importance of international expert involvement as it adds legitimacy, encourages participation in discussions, and supports the spirit of cooperation; these findings came from work between Israelis and Palestinians to create prevention and treatment programs in the region. Sweileh et al., (2014) also suggest that policy makers need to be more observant of the misuse of substances and create policies to limit the potential abuse.

There has been some progress in the region toward substance abuse and mental health treatment, yet much more is needed to promote evidence-based treatment delivered in an interdisciplinary and integrated manner. Partnering with Western providers and researchers, as well as policy makers, could help advance the efforts more quickly. The struggle to address addiction on a global scale is an issue for all countries of the world to embrace, and working together cooperatively and collaboratively is the only way to address this significant and detrimental issue to the world at large.

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Part III
Conclusion

Chapter 12
Putting It Together: Final Thoughts on Two Decades of Mental Health and Addiction Development Efforts

Patricia A. Findley and Richard Isralowitz

12.1 Introduction

Missiles flew and we ran for shelter, not an uncommon experience in Israel, but uncommon for the American editor (Dr. Findley) of this book. The conflict became poignantly real that day. The missiles came from Gaza through the skies to land on the campus of the university. It seemed unfathomable that the stories that are shown so frequently on the evening news unfolded in the bright blue sunny day in Beer Sheva that January day. Gaining understanding of what this meant for the region, what the impact of living with the stress on a daily basis piqued the curiosity of the researchers who contributed to this book. We chose to focus on mental health, addiction, and related resiliency through community supports to offer a barometer of the current, yet remainly hopeful for the future.

The Israeli editor of this text has been working in this field of mental health and addiction for 35 years, mostly in partnership with a Palestinian physician who coauthored chapters of this text. Their partnership, while it exists in the reality of regional conflict, transcends that barrier to focus on the individuals who live on either side to prompt mutual understanding and cooperation for the health and wellbeing of all people. Professor Isralowitz's work has been examining mutual concerns and opportunities in the spirit of collaboration; interpreting theory and applying learning into usable knowledge to advance the field.

P.A. Findley (✉)
School of Social Work, Rutgers University, The State University of New Jersey, New Brunswick, NJ, USA
e-mail: pfindley@ssw.rutgers.edu

R. Isralowitz
Spitzer Department of Social Work, Ben Gurion University, Beer Sheva, Israel

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12.2 Theoretical Underpinnings

The work discussed in this book is underpinned in the theory of the social construction of reality (Berger & Luckmann, 1966), customs, common interpretations, and social process. These perspectives can become part of a deeply rooted process with individuals playing roles based on potential misconceptions leading to an institutionalized notion. These notions become embedded and are, therefore, reality that has been embedded in the institutional fabric of society. Reality is therefore said to be socially constructed. These are the entrenched beliefs in the Middle East that present a conundrum for social service and other mental health specialists; the representations of reality are not shared realities of mutual interest. This lack of shared realities leads to conflict, war, and violence. These are some of the causes of stress this book highlights.

12.3 Coping and Resilience

Dr. Findley's interest in resilience and conflict mitigation became the cornerstone of the second half of the book. This led to the work with psychological first aid as a means to address conflict mitigation between Israeli and Palestinian mental health workers along with other colleagues from the United States and Israel. Studies have reported that psychological first aid does bolster resilience (Uhernik & Husson, 2009), yet the use of it across populations in conflict such as Israelis and Palestinians may be a first. By bringing these two groups of individuals together for a common dialogue around psychological first aid and the meaning of disaster response, they were able to challenge some of the specific narratives (Oren, Nets-Zehngut, & Bar-Tal, 2015) around support and intervention that the Israelis and Palestinians held to develop a more collective narrative over the meaning of mutual aid. Details of those efforts are found in Findley, Halpern, Rodriguez, and Vermeulen (2016).

It is clear that conflict in the social and political environments over the years have impacted those in the Middle East (Quouta & el-Sarra, 2002). It is also known that the response is varied by culture, depending on how the individuals construct their reality as well as how they experience their cultures. These differences need to be attended to in how we create interventions and provide services for these individuals. The groups may seem homogeneous to outsiders, but the Middle East is comprised of multiple countries, with many people, old and new, all in social and cultural transition. This was articulated in the chapter by Isralowitz, Afifi, Reznik, and Sussman (2016) noting stress factors including living conditions and adjustment among Palestinian and Israeli youth.

We also note that stress in the region is limited not only to the youth but also to mothers. Murphy (2016) addressed a parent and self-care intervention for substance-abusing mothers among women who were Israeli and Palestinian, with the study focusing on mothers with chronic illnesses such as diabetes, high blood pressure,

obesity, and other infectious diseases while living in the ongoing conflict. The use of IMAGE (Improving Mothers' parenting Abilities, Growth , and Effectiveness), Murphy's intervention has been shown to result in improvements in the parent–child relationship and in parent–child communication. Pilot work with mothers in the Middle East found this to be an approach that would be highly promising.

12.4 Substance Abuse and Mental Health

Overall, drug use and abuse has increased worldwide despite religious and cultural beliefs that might have averted it (Degenhardt & Hall, 2012), which contributes to the global burden of disease. Specifically, substance abuse among mothers has captured attention in Israel with outcomes in children shown to be violent (Maker, Shah, & Agha, 2005), and parental substance abuse can lead to children becoming substance abusers themselves (Arria, Mericle, Meyers, & Winters, 2012). Yehudai, Sarid, Reznik, Findley, and Isralowitz (2016) reported in this text a contradictory finding that mothers who use opiates had lower levels of stress compared to mothers who did not. Furthermore, they found that mothers who did abuse substances reported higher levels of suicidal thought or attempts, showed increased parental disappointment about the child, felt rejection by the child, and had difficulties in parental–child interactions. These researchers noted the importance of focusing on a gap in the literature—studies that focus on children under the age of 5 years old. Both parents, and not the mothers alone, need to be considered for intervention. Finally, they pointed to a high relapse rate that should also be addressed by any future studies, with an emphasis on ensuring that the intervention is culturally relevant (Yehudai et al., 2016).

Despite all that occur on a daily basis in the Middle East, resilience among these people has been shown to be remarkable. There are efforts to enhance the social safety nets of the Middle East and Northern Africa for the poor and the vulnerable. The goals of such enhancements to the social safety nets (SSNs) are to promote inclusion, livelihood, and resilience (Silva, Levin, & Morgandi, 2013). The impact of social contacts has been shown to mitigate the development of PTSD (post traumatic stress disorder) symptoms among general community members who have been exposed to traumatic events. For example, (Besser, Zeigler-Hill, Weinberg, Pincus, & Neria, 2015) point out in their study that individuals with low levels of intrapersonal resilience reported more PTSD symptoms over those with high levels of intrapersonal resilience in geographic areas exposed to low and high levels of rocket and missile fire.

The stress is also felt by immigrants in the Middle East. Acculturation of immigrants has been explored in this text through the lens of addiction treatment procedures (Resnik & Isralowitz, 2016), particularly those from the former Soviet Union. It is interesting to note that findings discussed in that chapter pointed toward segregation of the immigrants, at one time, for addiction services to overcome barriers

such as language and fears of marginalization within a mainstreamed group, but acculturation efforts in general should not be overlooked to enhance the individuals' transition to life in Israel.

The ongoing nature of the terrorism in the Middle East involves challenges for individuals' resilience but also how to manage as a unified community. The response to terrorism and mental health issues requires community involvement in solutions. The role of community in disaster relief efforts by mental health professionals was highlighted by Alvarez and Findley (2016), a chapter within this book. The authors note the role that media has played in more recent years has contributed to a shared sense of national crisis since the images are usually graphic and shown repeatedly, an issue identified by Bleich, Gelkopf, Melamed, and Solomon (2006). Collective trauma, such as large-scale violence and trauma, should be studied with an interdisciplinary approach (Robben & Su'arez-Orozco, 2000). This continued exposure impacts on the psychological level but also on the way people construct their realities and how they are shared as a community, as noted earlier. Robben and Su'arez-Orozco (2000) state that the care provided to survivors of the collective trauma should be interdisciplinary because the trauma occurs in a complex environment that interlocks psychic, social, political, economic, and cultural aspects.

The perspective of the interconnectedness of the influences on the individual gave rise to the chapter in this text on collaborative care (Findley, 2016). It has been well documented in the literature that integrated care took root in the United Kingdom in the 1980s to address financial issues in health care, but more recently collaborative care models have been shown to be effective with individuals with mental illness (Thota et al., 2012). However, the chapter indicates that at the present, more collaborative care needs to be provided, especially for those with mental health and addiction care needs in the Middle East, as it is also lacking in many other regions.

12.5 Conclusion and Future Directions

This chapter started off with the mention of a missile attack and the need for Israelis and visiting foreign scholars to run for safety. We gathered in a secure stairwell at the university awaiting a message of "all clear"—which came as cell phones began to ring again with worried family members finally being able to get through to see how loved ones were doing. People began to emerge from the stairwell, and the Israeli colleagues turned to the American visitors to ask if this would be a good time for lunch. A meal was the farthest thing from the visitors' minds, yet the question alone gave us insight in how many Israelis cope . They cope through maintaining routine and forward movement. This is clearly part of resilience, although, perspective is another component of this coping. Later that same afternoon when the group had moved into a classroom to provide a lecture ironically on disaster preparedness, one of the Israeli students pulled an American faculty member aside to ask, "Aren't you afraid?" After a moment of thinking and exhaling a deep breath, the faculty

member said, "No, I am much more comfortable with you all in the classroom, getting into a familiar routine." The student looked puzzled with the response and then said, "No, I mean you live so close to New York. How do you live knowing you may be shot any day on the street?" It clearly is a matter of perspective, isn't it?

No one knows what will happen in the Middle East in the years to come. The work discussed in this book discusses a single mission to address stresses that affect the mental health and addiction processes of the people of the Middle East: a human mission to create a better world for our future and those who come after us. A shared reality of cooperation is one hope to reduce the stress and conflict in the Middle East.

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