Downey and Chang's *Substance Use Disorders in Underserved Ethnic and Racial Groups* represents a fundamental and essential undertaking that rarely gets the attention it deserves. This volume successfully and remarkably "... curates important knowledge and practice recommendations" among a diversity of ethnoracial groups. Social and historical events are deftly discussed and placed in essential contexts for psychologists, psychiatrists, and other readers interested in substance use and misuse. The editors recognize, integrate, and discuss the fundamental centrality of ideas that are essential to the successful treatment of substance use disorders. Downey and Chang have gathered luminaries who present, discuss, and clarify key considerations of contemporary cultural competence, and matching treatments to ethnoracial groups (e.g., African Americans, Asian Americans, Hispanic/Latino Americans, and Native Americans). *Substance Use Disorders in Underserved Ethnic and Racial Groups* represents an integrated public health view that is fundamental to understanding the influence of social setting and cultural set on the process of substance abuse treatment. This volume is so very important: It deserves to be on the shelf of every clinician, policy maker, researcher, and student of substance use and misuse. As I reviewed this text, I kept wondering what kept the field so long to prepare a book of this focus and importance.

—**Howard J. Shaffer, PhD,** Morris E. Chafetz associate professor of psychiatry in the field of behavioral sciences, Harvard Medical School, Boston, MA; distinguished faculty, division on addiction, The Cambridge Health Alliance

This manuscript provides a thoughtful and compelling review of the multitude of ways to provide culturally responsive support to marginalized people of color to improve substance use disorder and mental health outcomes.

—**Hendrée E. Jones, PhD, LP,** professor, department of obstetrics and gynecology, senior advisor, UNC Horizons, School of Medicine, The University of North Carolina at Chapel Hill. Chapel Hill, NC, fellow of Division 28 American Psychological Association

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Introduction to Substance Use Disorders in Diverse Ethnoracial Groups

Understanding How We Got Here

Edward C. Chang and Christina A. Downey

Every prescription represents the imposition of one individual's choice upon another, transforming the consciousness of the person prescribed to into one that conforms with the prescriber's consciousness.

—FREIRE (1970)

According to a national survey conducted by the Substance Abuse and Mental Health Services Administration (2022), based on the widely used *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*; American Psychiatric Association, 2013) to identify substance use disorder (SUD), it has been estimated that 15.4% of U.S. adult population 18 years or older, or more than 38.7 million American adults, struggled with SUD in 2020. Of this estimate, 17.2 million (4 in 9 adults) struggled with illicit drugs, 27.6 million (7 in 10 adults) struggled with alcohol use, and 6.1 million (2 in 13 adults) struggled with both illicit drugs and alcohol. Moreover, 21.0% of U.S. adults, or more than 52.9 million American adults, are estimated to have struggled with mental illness, with 6.7% of U.S. adults, or more than 17.0 million American adults, struggling with both an SUD and a mental illness. Thus, whether considered independent of other mental illnesses (e.g., major depression, generalized anxiety, posttraumatic stress disorder) or in confluence with them, SUDs represent a major problem in the United States.

https://doi.org/10.1037/0000384-001
Substance Use Disorders in Underserved Ethnic and Racial Groups: Using Diversity to Help Individuals Thrive, C. A. Downey and E. C. Chang (Editors)

And, oftentimes, the effects of SUDs typically go well beyond the individual and impact others, from the family system to neighborhoods and communities (e.g., Butler & Bauld, 2005; Shumway et al., 2022; Skewes et al., 2019).

It is noteworthy that the prevalence rates of SUDs and mental illnesses vary by different ethnoracial groups (unfortunately, stable prevalence rates for Native American adults are not available; see Substance Abuse and Mental Health Services Administration, 2022). For example, the highest rate of adults struggling with SUDs is among African Americans at 15.4%, and the lowest was found for Asian and Pacific Islander Americans at 9.7%. Moreover, both African Americans and Hispanic/Latino Americans have very comparable rates of comorbid SUD and mental illness at 5.9% and 5.8%, respectively. In contrast, Asian Americans have a lower comorbid rate of 3.2%. Unfortunately, the identification of these important national rates does little to foster any meaningful insights into the complex causes, concomitants, and consequences of SUDs in these structurally vulnerable groups (e.g., Evans et al., 2017; Jegede, 2020; Sahker et al., 2020; Wu et al., 2013), nor to understand the strategies that would be most useful to treat and prevent SUDs in these groups (e.g., Alegria et al., 2011; Bommersbach et al., 2022; Matsuzaka & Knapp, 2020).

The primary rationale for developing the present volume was to curate important knowledge and practice recommendations on addressing SUDs in diverse ethnoracial groups. Dedicating separate chapters to the most commonly identified diverse racial groups in the United States allows in-depth discussion of the similar and distinct factors that influence these conditions. The structure of this volume—with chapters dedicated to each group covering epidemiology, historical context, assessment, treatment, and prevention of SUDs—permits scholarly and practice audiences to gain understanding of important nuances that can make a difference in future research and client recovery. At a time in U.S. history when focus on cultural differences in the human experience is experiencing a backlash from ideologues on the populist far-right (Weinstock, 2023), demonstrating the value of attending to diversity in the SUD arena provides an opportunity to unify disparate factions around a worthy common cause.

RECONCEPTUALIZING SUDS ON A SPECTRUM: MAKING PROGRESS FROM *DSM-IV* TO *DSM-5* (AND BEYOND)?

Nearly 20 years after the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (*DSM-IV*; American Psychiatric Association, 1994), the *DSM-5* (American Psychiatric Association, 2013) was published. Perhaps the most dramatic change made was in the diagnostic framework used to diagnose SUDs. Specifically, the diagnostic framework for identifying SUDs based on a person's 12-month history was changed from one based on a bifurcated model in which a distinction was made between *substance use* and *substance dependence* (American Psychiatric Association, 1994), each with a distinct set of symptom criteria (e.g., drinking interfering with caring for family was symptomatic of alcohol

misuse vs. drinking despite it causing health problems was symptomatic of alcohol dependence) to one based on a combined model in which substance use now resided across a spectrum of symptoms that would be rated by clinicians from mild SUD (presence of 2–3 symptoms) to moderate SUD (presence of 4–5 symptoms) to severe SUD (presence of 6 or more symptoms).

Beyond this major framework change, additional changes were made in the *DSM-5* (American Psychiatric Association, 2013). Previously, for example, adults would be diagnosed with alcohol misuse if one symptom was present. Thus, the diagnostic threshold for substance misuse was easy to meet in a society in which various substances (e.g., alcohol, caffeine, tobacco) were used or consumed ubiquitously by adults. In contrast, to meet the current criteria of (mild) alcohol use disorder, for example, an individual would have to be indicated with the presence of at least two or more symptoms. In a society in which diverse ethnoracial groups in the United States have historically been, and remain, the target of prejudice and discrimination (e.g., Gordon-Reed, 2002; Harris & Lieberman, 2013; Pettigrew, 1975), this change is significant in that more evidence is now required before a clinician can diagnose an individual with an SUD, leaving, in theory, lesser room for subjective interpretations in constructing a diagnosis (e.g., López, 1989; Matsuzaka & Knapp, 2020; Pavkov et al., 1989).

Also removed from the previous *DSM-IV* criteria for SUDs (American Psychiatric Association, 1994) is the identification of legal problems associated with substance use ("recurrent substance-related legal problems"). Because some marginalized ethnoracial groups might be at greater risk of legal problems due to visible and invisible structural barriers and social disparities (Gordon-Reed, 2002), they might be more likely to also be at risk of diagnostic bias for *DSM-IV* substance misuse and other psychiatric conditions (Garb, 2021). As a result, it is possible that past clinical diagnoses of substance misuse for members of marginalized groups were confounded by the effects of structural discrimination within the criminal justice system. Thus, for example, it would be unclear if, for some diverse ethnoracial individuals, a diagnosis of substance misuse was due to substance use behaviors, structural bias and discrimination, or both. In that regard, the *DSM-5* appears to have made some progress toward resolving a potential source of diagnostic confounding by eliminating a symptom that may, for some marginalized groups, be better viewed as a consequence of living in an unjust society, rather than as a consequence of a personal disease process.

Alternatively, added to the *DSM-5* criteria for SUDs (American Psychiatric Association, 2013), focusing on symptoms related to *impaired control*, is criterion 4, the identification of a strong desire or urge to use a substance (*craving*). Within this grouping, craving is one of four symptoms that focus on behavioral dysregulation (e.g., taking large amounts of the substance, unsuccessful efforts to decrease substance use). Yet, it is clear that some substances are inherently addictive (e.g., tobacco, cocaine) and are pharmacologically likely to produce cravings independent of the specific individual using the substance (United States Department of Health and Human Services, 2016). In other words, although the inclusion of cravings may prove to be a useful hallmark of SUDs in

adults, this new symptom criterion fails to implicate the complex pharmacological role of the substances themselves on the individual, and ultimately, the role of the larger systems that manufacture, distribute, and promote a psychological, if not pharmacological, craving for many of these substances.

Indeed, the process leading to the inclusion of this new symptom, like many of the other symptoms that have remained from the prior version in the *DSM-5*, continues to fail in promoting a more complex understanding of the SUD as a socially informed and determined outcome. For example, of the 11 symptoms indicative of SUDs in the *DSM-5*, only three symptoms (part of the *social impairment* grouping) explicitly make reference to the social context of substance use (e.g., continued use of the substance as the cause of problems with friends or family). The remaining eight symptoms focus on their presence "within" the person. This emphasis on the individual embodying the problem is in keeping with a traditional disease or medical model (e.g., dysfunction in neural networks, emotion dysregulation, genetic vulnerability; Hinshaw & Cicchetti, 2000; Prilleltensky, 1989, 1997; Woolfolk & Richardson, 1984), and does little to foster a more inclusive understanding and approach to treatment that takes into consideration the role of larger systemic factors impacting the individual (e.g., social injustice, community trauma, poverty; Eisenberg, 1995; Holland, 1978; Sarason, 1981).

Conscientization in the American Psychiatric Association, But at What Cost? The Killing of George Floyd and the Development of the *DSM-5-TR*

On May 25, 2020, 46-year-old George Floyd, a Black male U.S. citizen and father of a young daughter, was murdered in broad daylight by a White Minneapolis male police officer in front of several other Minneapolis police officers and a number of local witnesses (Hill et al., 2020). Although such horrific instances of social injustices have been going on for decades against marginalized groups who have been the victims of structural racism and discrimination throughout U.S. history (e.g., Gordon-Reed, 2002), this tragic event caught the attention of millions across the United States, and around the world, as disturbing eyewitness videos of the injustice being committed were quickly shared on various social media platforms for the entire world to see and judge. What ensued shortly thereafter were charged collective demonstrations of outrage, anger, and frustration by various groups around the world, most visibly driven by ongoing work by organizations such as Black Lives Matter. The work of such organizations also brought heightened attention to the disparate impact that the COVID-19 pandemic, persistent differences in maternal and infant mortality, and increasing incidence of gun violence had wreaked on vulnerable communities, for instance low-income populations and people of color. From a public health perspective, all four issues (police brutality, pandemic-caused morbidity and mortality, maternal and infant mortality, and injury and death from firearms) acutely illustrated race-related health disparities and a lack of adequate public action to address them. This represented a national awakening, or *conscientization* (Freire, 1970, 1975), in which one could no longer dismiss

the oppressive and fatal realities of social injustice and disparities experienced by marginalized groups in the United States.

Ironically, it was the George Floyd murder that mobilized the American Psychiatric Association to establish a special work group—the Ethnoracial Equity and Inclusion Work Group—charged to critically reexamine and revise the *DSM-5* to ensure that there was no systemic verbiage that allowed for ethnoracial bias in diagnosis, while at the same time using this as an opportunity to educate users of the *DSM-5* to carefully appreciate the social determinants of health, including a consideration of the systemic barriers that continue to place some marginalized groups in society at greater risk of trauma, poor health, and mental illness (see Moran, 2022). As a result, for example, given problems with earlier samples and studies of SUDs in Native American groups, a need for greater caution in considering prevalence rates of SUDs in Native Americans was indicated in the new *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (*DSM-5-TR*; American Psychiatric Association, 2022). While this may appear to represent a positive response taken by the American Psychiatric Association in the context of the Black Lives Matter movement to address existing problems in how diverse ethnoracial groups in America might have been unjustly diagnosed and treated in the past, two considerations seem worth noting here.

First, it is interesting to note that no major changes were made in comparable works in the field of general medicine. For example, the popular Merck Manual of Diagnosis and Therapy (Porter et al., 2018) did not undergo a critical reexamination and text revision of how medical illnesses are diagnosed as a consequence of the Black Lives Matter movement. This is because most medical conditions, compared with psychiatric conditions, are often based on a convergence of opinion drawn from multiple independent sources of evidence (e.g., clinical history, patient interview, physical examination, imaging and diagnostic testing, lab results). In contrast, diagnoses for psychiatric conditions do not typically require such an array of diverse and independent sources of convergent evidence. As a socially constructed product, the *DSM* not only represents a codification of disordered behavioral topography as determined by a consensus of a small group of experts, but it also represents a codification of the personal values of those experts and of U.S. society in general (Brandt, 1970; Bronowski, 1956; Prilleltensky, 1989; Watters, 2010). This is one of the reasons why Szasz (1961) long contended that mental illnesses, unlike medical conditions, represent socially determined constructs, and why he and others (e.g., Gorenstein, 1984; Rosenthal et al., 2020; Szasz, 2007) have pointed to a fundamental need to refocus the conversation away from whether or not mental illnesses are real and toward the more critical conversation of how should a diverse and inclusive society develop and apply equitable social policies to ensure the mental health and well-being of all of its members.

Second, and relatedly, one is left wondering if a careful review and revision of the English text (see Majid & Levinson, 2010; Padilla et al., 1991) used in the *DSM-5* for ethnoracial bias is sufficient for identifying and eliminating invisible

and interconnected biases, from epistemological to structural, that continue to exist in the *DSM* ecosystem. For example, one only needs to examine the backgrounds of those members of the various diagnostic work groups to conclude that they continue to represent a very exclusive group of predominantly WEIRD (Western, educated, industrialized, rich, and democratic) and privileged experts (Henrich et al., 2010; Meadon & Spurrett, 2010). And, although we appreciate American Psychiatric Association's recent efforts to urge users of the *DSM* to consider the role of social determinants of health, especially when making diagnoses involving members of diverse ethnoracial groups, history tells us that these raised concerns are the exception, rather than the rule, in the developmental history of the *DSM* over the past 70 years (American Psychiatric Association, 1952). In historical context, the American Psychiatric Association's efforts in producing the *DSM-5-TR* seem more reactionary, a result of fear and concern that chaos would enter and deconstruct their established ecosystem, than represent a fundamental effort to reappraise and reimagine the *DSM* from the ground up as a work that needs to be predicated first and foremost on a foundation of diversity, equity, and inclusivity. Thus, one is left with a sobering question, namely, do we need more blatant instances of social injustices and violence in the streets in order to trigger continued social progress in the development of future *DSM*s?

Although our concerns have thus far focused largely on the *DSM* ecosystem, it is not clear if newer alternatives to the *DSM* (e.g., Research Domain Criteria, Hierarchical Taxonomy of Psychopathology) will necessarily fare much better in addressing concerns about diversity, equity, and inclusivity, as long as the data (and those who collect and interpret them) for informing the taxonomy and nosology of mental illnesses, including of SUDs, remain heavily predicated on WEIRD or privileged members of society (Betancourt & López, 1993; Henrich et al., 2010; Sue, 1999). Nor does turning to a globally developed diagnostic system that long predates *DSM*, such as the *International Classification of Diseases*, necessarily capture the unique ethnoracial realities at work in the United States (Clark et al., 2017) as we seek to understand diverse experiences of mental disorders like SUDs. For example, the *International Classification of Diseases* and *DSM* governing and development bodies have progressed from working separately to much more collaboratively over time in understanding both mental disorder symptomatology and the respective strengths and weaknesses of their diagnostic systems, and while the *International Classification of Diseases* is praised for its international focus and close coordination with World Health Organization, the *DSM* is considered the more clinically useful of the two systems, especially within the United States (Clark et al., 2017). Therefore, selection of the so-called "best" system for understanding SUDs and other mental conditions in diverse ethnoracial groups is not at all straightforward. Whether it is the popular *DSM* or some alternative psychiatric "bible," our concern has more to do with the question of who are (and who are not) afforded privileges to interpret such works and justify their interpretations of it. In that regard, the present work seeks to hold both scientists and practitioners socially responsible for collaboratively

building culturally informed understanding, assessment, treatment and, ultimately, prevention programs to address SUDs in diverse ethnoracial groups.

History Matters: How Origin Stories Set the Arc for Symptomatology

The George Floyd murder also offers a tragic example of how racialized concepts and stereotypes grow and shift over history and influence majority interpretation of substance use. In Mr. Floyd's case, county medical examination authorities in Minneapolis performed routine drug screening as part of the autopsy after his death, finding that Mr. Floyd's body evidenced the presence of methamphetamine and fentanyl. The medical examiner ruled the death a homicide due to cardiopulmonary arrest attributable to the arresting officer exerting suffocating pressure with his knee to the back of Mr. Floyd's neck. The jury agreed with that evidence and convicted the officer of murder and manslaughter, sentencing him to over 22 years in prison. However, during trial, defense attorneys for the officer used the positive drug screen to try to shed doubt on whether the police officer's use of lethal force was what had actually killed Mr. Floyd. These attorneys placed the supposed inability to rule out drug overdose as the actual cause of death at the center of their defense case—and though both the forensic evidence and the determination of the jury should have put this argument to rest, there remains, even at the time of this writing, widespread misinformation and disinformation about the false narrative that drugs killed George Floyd (Marcelo, 2022). The attempt to blame Mr. Floyd's death not on the actions of an aggressor but instead on concurrent circumstances evocative of negative racialized stereotypes about Black people living below the federal poverty line, and those in urban areas who encounter law enforcement, drew protests from many commentators and editorial boards as a cynical ploy to activate the prejudices of the jury and exonerate the killer.

Factors all across the continuum from social disadvantage to outright authoritarian oppression have influenced the historical trajectories of various racial/ethnic groups in the United States—truly, since before the formal founding of the nation. These histories have influenced the physical, mental, and social health of these groups and their respective struggles with the use of different substances falls within this scope. At the same time, powerful cultural histories have protected different groups over time from certain substance use issues or offered pathways to recovery from them. For these reasons, we present some of these historical factors to set a context for the discussion of substance use assessment, treatment, and prevention in each group.

OVERVIEW OF THE PRESENT VOLUME

To confer a critical lens to our understanding of mental illness among marginalized ethnoracial groups, Downey, in Chapter 1, provides readers with a grounding introduction to the notion of cultural competence as it

may apply to understanding and treating SUDs in ethnoracial groups. The author begins with a thoughtful discussion of the diverse meanings of cultural competence as well as some of the ongoing controversies regarding the usefulness of culturally adapting treatment strategies for different ethnoracial groups. This is then followed by a critical appraisal of how system-level factors might impact the development and application of cultural competencies in treating SUDs in ethnoracial groups. Finally, this chapter ends with a brief but important review of some of the growing evidence supporting the inclusion of cultural competence in effectively treating SUDs in ethnoracial groups. Following this important chapter on cultural competence, we continue with a focus on SUDs across each of the four major ethnoracial groups examined in the present work, namely, African Americans, Asian Americans, Hispanic/Latino Americans, and Native Americans.

In Part II, Chapters 2 to 4 focus on SUDs in African Americans. In Chapter 2, Zapolski begins with the finding that national rates of SUDs for African Americans are lower than the national average and illustrates how the rates for African Americans are in fact strongly influenced by a range of factors (e.g., age, gender, nationality, type of substance used) that warrant consideration when trying to understand the presence of SUDs among African Americans. The author then delves into the how a complexity of historical events and experiences, from traditional customs practiced in Africa and the enslavement of Africans in the United States to the impact of war, have shaped and informed SUDs in African Americans. The author then discusses some of the ongoing risk factors (e.g., age of onset, discrimination, socioeconomic status, incarceration) and protective factors (e.g., social support, religiosity, racial identity) that have been associated with SUDs in African Americans. In Chapter 3, Redmond, Lewis, Parker, Dickens, and Malone focus on the role of cultural competency in understanding SUDs in African Americans, with particular attention to how cultural competency can help frame an understanding of disparities experienced by African Americans. These authors compare major conceptual models of cultural competencies and follow up with a critical discussion on ways that practitioners might apply such models to develop culturally informed assessments and treatments when working with African Americans. The authors also note the importance of considering the intersectionality of identities and how this may impact SUDs among some members of the African American community. Ending Part II, in Chapter 4, Burlew, Miller-Roenigk, McCuistian, Burlew, and Peteet provide a systematic appraisal of the literature focusing on prevention interventions for African American youths, with particular attention on interventions that have involved experimental or quasi-experimental designs. As these authors note, findings from prevention studies using these stringent designs have shown mixed levels of effectiveness in African American youths. This chapter then moves on to a critical discussion of the lingering gaps present in these studies and the chapter ends with a thoughtful discussion on how both culturally informed approaches and practices can advance better prevention efforts in working with African Americans at risk of SUDs.

In Part III, Chapters 5 to 7 focus on SUDs in Asian Americans. Beginning with Chapter 5, Park, Kaya, Brady, Pandes-Carter, and Iwamoto note that, as the fastest growing group in the United States, Asian Americans represent an important population to examine despite their apparent low rates of SUDs. These authors identify important trends and prevalence rates of SUDs in Asian American youths and adults, with attention to contextualizing variations that exist among different subgroups. This is followed by a thoughtful review of major risk and protective factors that need to be considered in understanding SUDs in Asian Americans, from vulnerabilities due to nativity/acculturation to strengths garnered through enculturation. In Chapter 6, Wong-Padoongpatt, Zane, and King begin with a review of common SUD assessment tools that have been used with Asian Americans. This is followed by an appraisal of different culturally informed clinical strategies that have been recognized by experts to be useful in treating SUDs with Asian Americans, ranging from strategies that address language barriers to treatment (e.g., use of interpreters), concerns about losing face and experiences of shame (e.g., working with the larger family unit), to challenges associated with treatment credibility (e.g., ethnic match with therapist) by Asian American clients. The authors end the chapter by noting some of the promising evidence for treatments that work as well as returning to their central concern regarding the need to find ways to incorporate more culturally informed strategies to improve effectiveness when treating SUDs in Asian Americans. In Chapter 7, Choi, Park, Pekelnicky, Lee, and Kim complete Part III with a focus on the prevention of SUDs in Asian Americans. These authors begin with an important discussion of the complexity of etiological factors (e.g., acculturation level, family process) that need to be considered in developing prevention programs focusing on Asian Americans. Using youth and parent data collected from the Midwest Longitudinal Study of Asian American Families, these authors examine the correlates and conditions associated with SUD symptoms in two distinct Asian American subgroups, namely, Korean Americans and Filipino Americans. From their investigation, the authors note the complex array of common (e.g., drinking initiation associated with greater parent–child conflict) and distinct patterns (e.g., drinking initiation associated with lower American identity for Koreans but not for Filipinos) found between these two Asian American subgroups. Implications of their findings point to the centrality of the family's role in SUDs and to the need for considering independent risk and protective factors, as well as their complex interplay, in developing effective prevention programs for SUDs in Asian American youths.

In Part IV, Chapters 8 and 9 focus on SUDs in Hispanic/Latino/a Americans. Beginning with Chapter 8, López and Melian describe the demography of the Latino/a American population in the United States and some of the contextual factors that may influence experimentation with—and subsequent dependence on—addictive substances. For example, these authors highlight trauma as a key factor in SUDs as well as the challenging physical occupations that this population tends to work in. In the dangerous and demanding work of farming and agriculture, for instance, a desire for pain and stress management heightens the

risk of opioid addiction. They go on to review several validated assessment tools with demonstrated value for use with these populations and describe psychosocial interventions worth clinical consideration (both those tailored for use with Latino/as and created for specific application with these groups). They close with clinical and research recommendations that can enhance treatment effectiveness with this group.

In Chapter 9, Lozano, Fernandez, Estrada, and Prado begin with a review of etiological factors linked to SUDs in Hispanic/Latino/a Americans, including references to the impact of discrimination and racism among members of this group. These authors then focus their attention to a thoughtful discussion of factors (e.g., sexual orientation, prior experience with the criminal justice system) during adolescence that place varying subgroups of Hispanic/Latino American youths at greater risk of SUDs. The authors then focus their attention on an appraisal of how primary care might represent an optimal context in which intervention and prevention for SUDs in Hispanic/Latino youths might be approached, but they go further to note the importance of a multilevel approach, including the larger community context (e.g., preventing access to substances in the local community), school context (e.g., promoting antidrug norms), family context (e.g., parent skills training), and peer context (e.g., use of model peer leaders). These authors end their chapter with a critical discussion of the problem in the equitable implementation of interventions offered to Hispanic/Latino Americans and some solutions to address this inequity (e.g., use of telehealth interventions).

In Part V, Chapters 10 to 12 focus on SUDs in Native Americans/Alaska Natives. In Chapter 10, Evans-Campbell and Walters begin with a critical appreciation of the fact that although Native Americans/Alaska Natives make up a smaller percentage of the U.S. population, they often have been found to have the highest risk of SUDs, which in turn has been linked to chronic health problems, including premature death. The authors discuss some of the complex factors that need to be considered in understanding Native Americans/Alaska Natives as a very diverse group, across 573 tribes, 217 indigenous languages, and residence across different U.S. states. With these considerations in mind, the authors then provide a careful historical analysis of some of the early external factors that appear to be linked to alcohol use in Native Americans/Alaska Natives, in particular, the role of colonialism and varying government policies placed on these groups. The authors further present a critical discussion of the opioid epidemic and how it has had an unusually detrimental impact (e.g., high overdose death rate) on Native Americans/Alaska Natives relative to other groups and also points to the growing vulnerability present in Native American/Alaska Native youths to SUDs. This chapter concludes with a useful discussion of major risk (e.g., community trauma, microaggressions) and protective factors (e.g., culture, spirituality) that should be considered when working with Native Americans/Alaska Natives at risk of SUDs.

In Chapter 11, French and Downey reiterate the complex history and challenges experienced by Native Americans/Alaska Natives, requiring efforts

to treat SUDs in these groups to be mindful of such complexities. These authors then provide a life framework for assessing and treating SUDs in Native Americans/Alaska Natives that is predicated on the notion of tribal life stages (e.g., adulthood, elders). For example, the authors note that assessments of substance experimentation in the infancy/childhood stage among Native Americans/Alaska Natives might not be a reliable marker of substance use in later life stages. This leads the authors to review some notable assessments tools that have been used to identify SUDs in Native Americans/Alaska Natives, but they emphasize the need for more culturally informed assessments that are mindful of cultural values and preferences of tribal peoples. A similar review is made of modified treatments that have been used to focus on SUDs in Native Americans/Alaska Natives, including some that have been culturally informed (e.g., Medicine Wheel, indigenous religious ceremonies, sweat lodge) and shown to have promising impact in treating SUDs in these groups. The authors end their chapter with a critical reflection on the diverse ways in which both researchers and practitioners might be able to improve SUD services offered to Native Americans/Alaska Natives. In Chapter 12, Wagner, Lowe, and Baldwin situate their discussion of the prevention of SUDs in Native Americans/Alaska Natives with a recognition of the living historical trauma experienced by members of this diverse community, before moving on to a thoughtful discussion of established interventions (e.g., ecological family therapy) that have shown some positive evidence for treating SUDs in tribal peoples. This said, some of the limitations of these interventions are discussed (e.g., high cost to implement ecological family therapy). Moving to more culturally informed strategies, the authors note the potential therapeutic value of using talking circles as a traditionally meaningful way for Native Americans/Alaska Natives to leverage the collective and interconnected strength and wisdom of the community to help reduce or prevent SUDs and discuss how culturally informed approaches may range from those that are merely culturally adapted (important cultural elements are added) to those that are culture centered (based on important cultural elements) to treat and prevent SUDs in Native Americans/Alaska Natives, especially among the young (e.g., National Indian Youth Leadership Project). In the context of living historical trauma, the authors end by underscoring the pressing need for true systemic change if we are to be more effective in treating and preventing SUDs in Native Americans/Alaska Natives.

Lastly, Part VI concludes with a discussion of training issues in cultural competence and SUDs. Specifically, in Chapter 13, Downey and Chang review the state of the literature on graduate programs and continuing education training for SUD providers seeking to adopt a culturally competent approach in their practice. In short, evidence indicates that despite broad recognition that such training is critical to supporting the SUD treatment needs of a rapidly changing population, opportunities for providers to be guided in their learning in this area are woefully inadequate. Still, such underresourcing offers great opportunity for scholars and practitioners to create meaningful impact in this area of mental health service.

Some acknowledgement of our collective approach as editors and contributors to language used in this volume should be shared. As terminology in writings on race and racial groups is continuously evolving, we have opted to align our volume with the APA inclusive language guidelines released in 2021 and still in effect in 2023 (American Psychological Association, 2021). In certain cases, however, we deemed it appropriate to support author choices regarding specific terms, so the volume is not fully uniform on this point. In addition, as of the time of this writing, some titles of organizations or source materials contain terms (e.g., substance "abuse") that do not align with the current guidelines. We are grateful for the reader's understanding on such issues.

OUR FINAL THOUGHTS

As editors of previous volumes that have focused on mental illness and positive well-being in ethnoracial communities (Chang et al., 2016, 2018), it is clear to us that there is a noticeable divide in the approaches used to understand and work with diverse groups. On the one hand, science is typically predicated on using a nomothetic approach to identify stable and enduring patterns that can be theoretically generalized and applied universally to all humans. On the other hand, practice is typically predicated on applying an ideographic approach to appreciate concrete factors in vivo that may influence an individual's presenting problem and potential solutions to it. Herein lies the conundrum between science and practice, as they involve competing approaches. Although scientific efforts to identify major moderators (e.g., risk factors, protective factors) that impact SUDs in diverse ethnoracial groups remain important for culturally enhancing existing practice, the therapeutic context is one that needs to be mutually empowering, especially when a culturally embodied client of color is involved. For practitioners, scientists can tell us what major cultural elements not to miss. In contrast, the culturally embodied client of color can tell us what cultural elements we did miss. It is our hope that the present volume helps us to keep the focus on finding diverse ways to provide meaningful support to culturally embodied people of color in our common goal to eliminate all forms of social oppression and to promote mental health for all if our society is to thrive.

REFERENCES

Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment of substance use disorders and co-occurring disorders for ethnic/racial minority youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(1), 22–31. https://doi.org/10.1016/j.jaac.2010.10.005

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.).

American Psychological Association. (2021). *Inclusive language guidelines*. https://www.apa.org/about/apa/equitydiversity-inclusion/language-guidelines.pdf

Betancourt, H., & López, S. R. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist*, *48*(6), 629–637. https://doi.org/10.1037/0003-066X.48.6.629

Bommersbach, T. J., Jegede, O., Stefanovics, E. A., Rhee, T. G., & Rosenheck, R. A. (2022). Diagnostic remission of substance use disorders: Racial differences and correlates of remission in a nationally representative sample. *Journal of Substance Abuse Treatment*, *136*, Article 108659. https://doi.org/10.1016/j.jsat.2021.108659

Brandt, L. W. (1970). American psychology. *American Psychologist*, *25*(12), 1091–1093. https://doi.org/10.1037/h0030289

Bronowski, J. (1956). *Science and human values*. Julian Messner.

Butler, R., & Bauld, L. (2005). The parents' experience: Coping with drug use in the family. *Drugs: Education, Prevention & Policy*, *12*(1), 35–45. https://doi.org/10.1080/0968763042000275308

Chang, E. C., Downey, C. A., Hirsch, J. K., & Lin, N. J. (Eds.). (2016). *Positive psychology in racial and ethnic groups: Theory, research, and practice*. American Psychological Association.

Chang, E. C., Downey, C. A., Hirsch, J. K., & Yu, E. A. (Eds.). (2018). *Treating depression, anxiety, and stress in ethnic and racial groups: Cognitive behavioral approaches*. American Psychological Association.

Clark, L. A., Cuthbert, B., Lewis-Fernández, R., Narrow, W. E., & Reed, G. M. (2017). Three approaches to understanding and classifying mental disorder: *ICD-11*, *DSM-5*, and the National Institute of Mental Health's Research Domain Criteria (RDoC). *Psychological Science in the Public Interest*, *18*(2), 72–145. https://doi.org/10.1177/1529100617727266

Eisenberg, L. (1995). The social construction of the human brain. *The American Journal of Psychiatry*, *152*(11), 1563–1575. https://doi.org/10.1176/ajp.152.11.1563b

Evans, E. A., Grella, C. E., Washington, D. L., & Upchurch, D. M. (2017). Gender and race/ethnic differences in the persistence of alcohol, drug, and poly-substance use disorders. *Drug and Alcohol Dependence*, *174*, 128–136. https://doi.org/10.1016/j.drugalcdep.2017.01.021

Freire, P. (1970). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). New York, Continuum.

Freire, P. (1975). Cultural action for freedom. *Harvard Educational Review Monograph*, *1*. https://doi-org.proxy.lib.umich.edu/10.17763/haer.68.4.656ku47213445042

Garb, H. N. (2021). Racial bias and gender bias in the diagnosis of psychological disorders. *Clinical Psychology Review*, *90*, Article 102087. https://doi.org/10.1016/j.cpr.2021.102087

Gordon-Reed, A. (Ed.). (2002). *Race on trial: Law and justice in American history*. Oxford University Press.

Gorenstein, E. E. (1984). Debating mental illness: Implications for science, medicine, and social policy. *American Psychologist*, *39*(1), 50–56. https://doi.org/10.1037/0003-066x.39.1.50

Harris, F. C., & Lieberman, R. C. (Eds.). (2013). *Beyond discrimination: Racial inequality in a postracist era*. Russell Sage Foundation.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, *33*(2–3), 61–83. https://doi.org/10.1017/s0140525x0999152x

Hill, E., Tiefenthäler, A., Triebert, C., Jordan, D., Willis, H., & Stein, R. (2020). How George Floyd was killed in police custody. *The New York Times*. https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html

Hinshaw, S. P., & Cicchetti, D. (2000). Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Development and Psychopathology*, *12*(4), 555–598. https://doi.org/10.1017/s0954579400004028

Holland, J. G. (1978). Behaviorism: Part of the problem or part of the solution? *Journal of Applied Behavior Analysis*, *11*(1), 163–174. https://doi.org/10.1901/jaba.1978.11-163

Jegede, O. (2020). Addiction, race, and the structurally vulnerable. *The American Journal on Addictions*, *29*(5), 428–429. https://doi.org/10.1111/ajad.13090

López, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychological Bulletin*, *106*(2), 184–203. https://doi.org/10.1037/0033-2909.106.2.184

Majid, A., & Levinson, S. C. (2010). WEIRD languages have misled us, too. *Behavioral and Brain Sciences*, *33*(2–3), Article 103. https://doi.org/10.1017/s0140525x1000018x

Marcelo, P. (2022, October 21). Experts: George Floyd died from knee to neck, not drug overdose. *AP News*. https://apnews.com/article/fact-check-george-floyd-kanye-west-police-397984860325

Matsuzaka, S., & Knapp, M. (2020). Anti-racism and substance use treatment: Addiction does not discriminate, but do we? *Journal of Ethnicity in Substance Abuse*, *19*(4), 567–593. https://doi.org/10.1080/15332640.2018.1548323

Meadon, M., & Spurrett, D. (2010). It's not just the subjects—There are too many WEIRD researchers. *Behavioral and Brain Sciences*, *33*(2–3), 104–105. https://doi.org/10.1017/S0140525X10000208

Moran, M. (2022). Impact of culture, race, social determinants reflected throughout new *DSM-5-TR*. *Psychiatric News*. https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.03.3.20

Padilla, A. M., Lindholm, K. J., Chen, A., Durán, R., Hakuta, K., Lambert, W., & Tucker, G. R. (1991). The English-only movement: Myths, reality, and implications for psychology. *American Psychologist*, *46*(2), 120–130. https://doi.org/10.1037/0003-066X.46.2.120

Pavkov, T. W., Lewis, D. A., & Lyons, J. S. (1989). Psychiatric diagnoses and racial bias: An empirical investigation. *Professional Psychology: Research and Practice*, *20*(6), 364–368. https://doi.org/10.1037/0735-7028.20.6.364

Pettigrew, T. F. (Ed.). (1975). *Racial discrimination in the United States*. Harper & Row.

Porter, R. E., Kaplan, J. L., Lynn, R. B., & Reddy, M. T. (Ed.). (2018). *The Merck manual of diagnosis and therapy* (20th ed.). Merck.

Prilleltensky, I. (1989). Psychology and the status quo. *American Psychologist*, *44*(5), 795–802. https://doi.org/10.1037/0003-066X.44.5.795

Prilleltensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. *American Psychologist*, *52*(5), 517–535. https://doi.org/10.1037/0003-066X.52.5.517

Rosenthal, R. N., Welsh, J. W., Connery, H. S., Barnett, B. S., DeVido, J., Hill, K., Levin, F. R., Williams, A. R., & Greenfield, S. F. (2020). Advocacy and public policy efforts of the American Academy of Addiction Psychiatry. *The American Journal on Addictions*, *29*(5), 401–406. https://doi.org/10.1111/ajad.13085

Sahker, E., Pro, G., Sakata, M., & Furukawa, T. A. (2020). Substance use improvement depends on race/ethnicity: Outpatient treatment disparities observed in a large US national sample. *Drug and Alcohol Dependence*, *213*, Article 108087. https://doi.org/10.1016/j.drugalcdep.2020.108087

Sarason, S. B. (1981). An asocial psychology and a misdirected clinical psychology. *American Psychologist*, *36*(8), 827–836. https://doi.org/10.1037/0003-066X.36.8.827

Shumway, S. T., Bradshaw, S. D., Zielinski, M., D'Aniello, C., Kimball, T. G., & Soloski, K. (2022). A multifamily group curriculum for family members of individuals with substance use disorders: Updates, perceptions, and outcomes. *Alcoholism Treatment Quarterly*, *40*(3), 358–378. https://doi.org/10.1080/07347324.2021.2019649

Skewes, M. C., Hallum-Montes, R., Gardner, S. A., Blume, A. W., Ricker, A., & FireMoon, P. (2019). Partnering with native communities to develop a culturally grounded intervention for substance use disorder. *American Journal of Community Psychology*, *64*(1–2), 72–82. https://doi.org/10.1002/ajcp.12354

Substance Abuse and Mental Health Services Administration. (2022). *The National Survey on Drug Use and Health: 2020*. https://www.samhsa.gov/data/sites/default/files/reports/rpt37924/2020NSDUHNationalSlides072522.pdf

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist*, *54*(12), 1070–1077. https://doi.org/10.1037/0003-066X.54.12.1070

Szasz, T. S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. Harper & Row.

Szasz, T. S. (2007). *The medicalization of everyday life*. Syracuse University Press.

U.S. Department of Health and Human Services. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*.

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. Free Press.

Weinstock, D. M. (2023). Multiculturalism as harm reduction. *Res Publica*. Advance online publication. https://doi.org/10.1007/s11158-023-09585-4

Woolfolk, R. L., & Richardson, F. C. (1984). Behavior therapy and the ideology of modernity. *American Psychologist*, *39*(7), 777–786. https://doi.org/10.1037/0003-066X.39.7.777

Wu, L.-T., Blazer, D. G., Gersing, K. R., Burchett, B., Swartz, M. S., Mannelli, P., & the NIDA AAPI Workgroup. (2013). Comorbid substance use disorders with other Axis I and II mental disorders among treatment-seeking Asian Americans, Native Hawaiians/Pacific Islanders, and mixed-race people. *Journal of Psychiatric Research*, *47*(12), 1940–1948. https://doi.org/10.1016/j.jpsychires.2013.08.022