Summer 8-20-2017

EXAMINATION OF MULTIDIMENSIONAL ACCULTURATION THEORY AND ACCULTURATION PROCESS ON LATINAS/OS IN COMMUNAL RECOVERY HOMES

Roberto Lopez Tamayo
DePaul University, rlopezta@depaul.edu

EXAMINATION OF MULTIDIMENSIONAL ACCULTURATION THEORY AND ACCULTURATION PROCESS ON LATINAS/OS IN COMMUNAL RECOVERY HOMES

A Dissertation Proposal

To be Presented in Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy in Clinical Psychology

BY

ROBERTO LOPEZ-TAMAYO

June 12, 2017

Department of Psychology

College of Science and Health

DePaul University

Chicago, Illinois

Dissertation Committee

Leonard A. Jason, Ph.D.

Chairperson

Bernadette Sanchez, Ph.D.

Department Reader

Verena Graupmann, Ph.D.

Department Reader

Leah C. Neubauer, EdD

Reader

Lourdes Torres, Ph.D.

Reader

Acknowledgements

I would like to express my sincere gratitude to Dr. Leonard Jason for allowing me to be part of the Latina/o Oxford House project, first as a volunteer and later as a graduate student. His guidance, patience, motivation and immense knowledge have enlightened my academic development. I would like to thank Drs. Josefina Alvarez, Bernandette Sanchez, and Verena Graupmann for her guidance and support in the completion of this project. My sincere thank goes to every person that worked tirelessly to carry out this research project: participants, research assistants, graduate students, and external collaborators. My dissertation would not have been possible without their collaboration. I would like to thank my parents and siblings for being an example of tenacity and perseverance. Finally, I would like to thank my wife and my son, Irene and Robertito, for their unconditional support through all these years.

Biography

The author was born in Guadalajara, Jalisco, Mexico. He attended the Seminary of Guadalajara and received his Bachelor of Arts degree from University of Valle of Atemajac in 2002. The author moved to the United States in 2006 to pursue a career in Psychology. He completed a Master's in Clinical Counseling from The Chicago School of Professional Psychology in 2009, and a Master of Arts in Clinical Psychology in 2013.

Table of Contents

Dissertation Committee……ii
Acknowledgements……...iii
Biography……..iv
Table of Contents……..v
Table of Figures……vii
List of Tables……viii
Abstract……ix
CHAPTER I
INTRODUCTION……...1
Substance Abuse Treatment 4
Theories and Ecological Factors Implicated in Substance Abuse Recovery 6
Theories in Acculturation Research..... 10
Methodological Approach to Acculturation 19
Communal settings: Where Context of Reception and Recovery Environment Converge 26
Rationale 30
Statement of Hypotheses……35
Research Questions……36
CHAPTER II
METHODS……37
Participants..... 37
Setting and Procedures..... 40
Measures……42
CHAPTER III
RESULTS AND ANALYSES……...47
CHAPTER IV
DISCUSSION……75
Conclusions, Limitations, and Implications..... 93
CHAPTER V
SUMMARY……102
References……104

Appendix A.
Consent Form (English and Spanish Version) 134
Appendix B
Demographic Questionnaire (English and Spanish Version) 154
Appendix C
Bidimensional Acculturation Scale (English and Spanish Version) 159
Appendix D
Psychological Acculturation Scale (English and Spanish Version) 164
Appendix E
Important People Inventory (English and Spanish Version) 169
Appendix F
House Processes Questionnaire (English and Spanish Version) 178

Table of Figures

FIGURE 1. Conceptual model for Hypotheses Ia and Ib……53

FIGURE 2. Statistical diagram of the conditional process model for Hypotheses Ia and Ib…… 54

FIGURE 3. Analytical model for Hypothesis II……. 59

FIGURE 4. Interaction between length of stay in OH and OH condition……61

FIGURE 5. Interaction between length of stay in the U.S. and Latina/o cultural practices on drug use in the past six months (baseline)……...63

FIGURE 6. Analytic model for research question 2 ……...64

FIGURE 7. Interaction between relationship with OH residents and treatment condition……...65

FIGURE 8. Analytical model for research question 3…….68

FIGURE 9. Analytical model for research question 4…….70

List of Tables

TABLE 1. Sociodemographic characteristics of Latina/o Immigrants and U.S. mainland-born Latinas/os……52

TABLE 2. Correlations for the variables of interest (Hypotheses Ia and Ib)…...53

TABLE 3. Correlations for the immigrant and U.S. mainstream-born group…..54

TABLE 4. Model coefficients for the conditional process model for Hypothesis Ia……..57

TABLE 4. Model coefficients for the conditional process model for Hypothesis Ib …….59

TABLE 6. Correlations for the variables of interests for Hypothesis II……..60

TABLE 7. Correlation for acculturation dimensions and acculturation process.63

Abstract

Disparities in access and utilization of substance abuse treatment (SAT) among Latinas/os, accentuated by the rapid growth of this population are creating a public health issue. Among those in need of SAT, only 7.7% receive treatment and nearly half of these individuals complete SAT or continue their recovery in a controlled environment. Additionally, Latinas/os who complete SAT reported their needs were not met in treatment. Although substance abuse literature has given more consideration to environmental factors and social support in relation to treatment outcomes, current substance abuse models fail to address important contextual and cultural aspects for Latinas/os in recovery. The inclusion of acculturation in substance abuse models is needed to further our understanding of the socio cultural and contextual factors implicated in the recovery process among Latinas/os.

Research that examines acculturation theories using a critical lens is needed to expand current notions of acculturation and how these theories can be applied to other populations and settings. Acculturation theorists propose the use of a multidimensional framework to explore, not only changes in higher order constructs but also in the acculturation process to inform culturally-grounded prevention programs. Specifically, investigating the role of community-based recovery settings as a catalyst for acculturation process on Latinas/os who completed SAT would shed light on parallel processes that Latinas/os experience as part of the recovery process. Research in this area is critical to inform and develop sustainable and effective substance abuse aftercare for Latinas/os.

The aim of the proposed study is twofold: a) test out a multidimensional acculturation model (Schwartz et al., 2010) on a sample of 135 Latinas/os (M_{age}= 36.3; *SD*±10.4, 117 males, 49% immigrants) who recently completed SAT. Specifically, the proposed study examine behavioral acculturation (i.e., Latina/o cultural orientation, U.S. mainstream culture orientation) and attitudinal acculturation (i.e., perceptions toward the Latina/o culture and the U.S. mainstream culture) as moderators of the association between generational status (i.e., immigrants and U. S. mainland-born Latinas/os who completed SAT) and alcohol and drug use in the past six months (baseline). Additionally, changes in acculturation in relation to the length of stay in Latinas/os assigned either to traditional community-based recovery homes or culturally modified community-based recovery homes are explored.

The second aim is to explore the acculturation process on a sample of 84 Latina/o OH residents (M_{age} = 37; *SD*±10.1, 68 males, 52% U.S. mainland-born Latinas/os) using critical acculturation (Chirkov, 2009) and segmented assimilation theories (Portes and Rumbaut, 2002). Data from the six-month follow-up are employed to answer the following questions: (1) In light of the immigrant paradox, what acculturation dimensions are associated with substance abuse lifetime? (2) Does treatment setting moderate the association between length of time in OH and house process and house environment? And if so, are changes in acculturation processes correlated with acculturation dimensions? (3) Does treatment setting moderate the association between length of stay in OH and changes in social network density and composition? And 4) does treatment setting

moderate the association between acculturation processes and substance use sobriety among Latina/o residents?

Overall, results from the proposed analyses will provide a better understanding of how multiple acculturation dimensions operate at the individual level. Similarly, the examination of the context of reception as well as social networks in promoting sobriety is relevant for the applicability of acculturation research. More important, findings from acculturation research should provide policy makers, health providers and community members with a better understanding of the mechanisms, interpersonal dynamics, and environmental conditions that impact Latina/o immigrants and their immediate descendants' recovery process from substance abuse.

CHAPTER I

INTRODUCTION

With a population exceeding 52 million, Latinas/os are the largest and fastest growing minority in the United States (Motel & Patten, 2013). Immigration has contributed to the growth of Latina/o population, with a significant number of foreign-born Latinas/os arriving after 1990 (Grieco et al., 2012; Census Bureau, 2010). Latina/o immigrants comprise 36% of the total Latina/o population (Motel & Patten, 2013) and most of them are middle age (age 35 and over) (Vega, Rodriguez, & Gruskin, 2009). Conversely, 38% of Latinas/os are born in the U.S. or second generation (Pew Research Center, 2013). However, the growth rate experienced by Latinas/os, three times faster than the total U.S. population (14%), contrasts with the lack of access to services (Ennis, Rios-Vargas, & Albert, 2011) and particularly substance abuse treatment.

National data revealed that 9.7% of Latinas/os met criteria for substance abuse and dependence in 2010 (NSDUH, 2011). Disparities in access utilization are observed over the last decade, where Latinas/os were less likely than other ethnic groups to receive substance abuse treatment (SAT) (9% vs. 10.5% respectively) (NSDUH, 2011). Among those in need of services, 7.7% received treatment, and only 58% completed treatment or were transferred to a controlled environment (NSDUH, 2011). Although aggregate rates of substance abuse among Latinas/os are lower than the national average (NSDUH, 2011), what is notable is the increase in those who are in need and seek substance abuse treatment (Guerrero et al., 2013).

The literature on substance abuse treatment (SAT) indicates that successful completion of treatment ranges from 25% to 75%, depending on the treatment modality (Jacobson, 2004). Although there have been efforts to provide a wide array of services for individuals with substance abuse disorders (Koh, Graham, & Glied, 2011), a recent survey on service utilization indicates that dropout rates are increasing among adults (Sahker, Toussaint, Ramirez, Ali, & Arndt, 2015). Among those who complete SAT, only less than a third (31%) remain abstinent (Dutra et al., 2008).

The sparse research on access and substance abuse treatment utilization among Latinas/os shows mixed results (Amaro et al., 2005; De La Rosa, Holleran, Rugh, & MacMaster, 2005; Guerrero, 2013). While some studies suggest that Latinas/os access SAT at the same rate than European Americans or African Americans (Jacobson, Robinson, & Bluthenthal, 2007), other studies indicate that Latinas/os encounter more barriers to access SAT (Arndt, Acion, & White, 2013; Robles et al., 2001; Schmidt, Greenfield, & Mulia, 2006), receive fewer services (Wells et al., 2001), receive less informal treatment options (Alegria et al., 2011), are less satisfied with treatment (Tonigan, 2003), and are less likely to complete SAT than other ethnic groups (Guerrero et al., 2013; Marsh et al., 2009; Vega et al., 2009). Similarly, Latinas/os who utilized and completed SAT reported their needs were not met in treatment (Mulvaney-Day, DeAngelo, Chen, Cook, & Alegria, 2012). These results suggest that traditional substance abuse models may fall short of addressing the complex needs of Latinas/os, increasing the odds of relapsing (Alvarez et al., 2004).

The combination of contextual and cultural factors may contribute to poor treatment utilization and outcomes among Latinas/os. Although the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) calls for the incorporation of cultural aspects at all different stages of substance use prevention and treatment (i.e., screening, assessment, placement, aftercare and recovery services, program development, and research), intake assessments and discharge planning may overlook individual needs that are important for substance use recovery process, particularly for those from ethnic minorities (Guerrero et al., 2013). Recently, unemployment and housing instability were found to largely contribute to lower treatment completion among Latinas/os (Saloner & LeCook, 2013). These findings indicate the need for research to understand key cultural and social aspects that inform substance use prevention and services for Latinas/os (Amaro et al., 2005; Guerrero et al., 2013).

The etiology of Latina/o substance use has been widely explored on Latina/o adolescents (Johnson, 2007; Martinez, 2006; Pokhrel et al., 2013; Szapocznik et al., 2007; Vega & Gil, 1998) and, to a lesser extent, on Latina/o adults (Alegria et al., 2006; Miller, 2011; Vega et al., 2009; Fish et al., 2015). Among the factors implicated in substance abuse, acculturation has been associated with substance misuse on Latina/o immigrants (Ojeda, Patterson, & Strarthdee, 2008) and U. S. born Latina/os (See Canino et al., 2008; Vega, Aldrete, Kolody, & Aguilar-Gaxiola, 1998). However, most acculturation models have been criticized for assessing aspects of acculturation (i.e., language, cultural practices), while failing to examine the acculturation process (Chirkov, 2009). By

the same token, the majority of the designs employed to study acculturation are cross-sectional and used data from non-clinical national databases (Ojeda et al., 2008). However, little is known about the role of acculturation dimensions in the recovery process of Latinas/os in recovery from SUDs. The use of a theory-driven acculturation model may further our understanding of the socio cultural and contextual factors that may lead to relapse on Latina/o recovery addicts (Alvarez et al., 2004). More important, research in this area is critical to inform and develop sustainable and effective substance abuse aftercare for Latinas/os.

Substance Abuse Treatment

SAT is intended to help individuals to stop compulsive use of alcohol and illicit drugs (Volkov, 2011). Treatment is delivered in different settings (inpatient, outpatient, and residential); adopt different modalities (i.e., cognitive-behavioral therapy, contingency management, detoxification, or a combination of medication management and psychotherapy); and varies in length of treatment based on the drug of choice and addiction severity. Treatment outcomes may differ based on individual factors including severity of substance abuse disorder, drug of choice, fewer formal education, income, employment status, and perception towards treatment (Laudet & Stanick, 2010).

The cognitive-behavioral (CB) approach is widely used in the treatment of substance abuse (Centers for Substance Abuse Treatment, 1999). One of the advantages of this approach is the wide array of interventions based on the level of functioning or addiction severity. The behavioral approach posits that substance abuse is a learned behavior pattern that can be modified by changing

the reinforcement contingencies (O'Brien & Childress, 1992). Substance abuse can be addressed through extinction (O'Brien et al., 1990), counter-conditioning (Rimmele et al., 1995), contingency management (Silverman et al., 1998), and coping skills training (Rotgers, 1996). Under a cognitive approach, substance use behavior is influenced by individuals' attitudes, perceptions, and attributions. These attitudes and perceptions -shaped by previous experiences and the environment- are used to appraise situations that inform substance use behavior (Beck & Liese, 1998).

Empirical evidence indicates that better treatment outcomes are observed when substance abuse treatment last approximately 90 days or longer (Simpson et al., 1997). In a non-experimental longitudinal study using nationwide data on treatment duration, reductions in cocaine use, illegal activity, and increases in full-time employment were found one year after SAT completion in those with longer treatment duration (Hubbard, Craddock, & Anderson, 2003). Despite the existing empirical evidence, subsidized and private health care plans offer short stays at substance abuse treatment programs (e.g., 20-30 days and in some cases only a few days). Such limited time frame living in a controlled environment results insufficient to detoxify the body from illicit substances and promote behavior change (Hubbard et al., 2003).

Recently, more attention has been given to the environment to which individuals in recovery are exposed (Jacobson, 2004). An array of community factors, including drug availability (Molina, Alegria, & Chen, 2012), the lack of occupational opportunities (Sahker et al., 2015), and the fewer resources available

increase the likelihood of relapse (Arndt, Acion, & White, 2013). Particularly, the combination of brief SAT and exposure to negative contextual factors increase the likelihood of relapse on Latinas/os with substance abuse problems (Amaro et al., 2005). Despite constant calls for the development of culturally competent evidence-based treatment (EBT) for Latinas/os (SAMHSA, 2014), existing EBTs are normed on the general population (i.e., European Americans), failing to address cultural aspects that are relevant for this ethnic group (Szapocznik, Lopez, Prado, Schwartz, & Pantin, 2006). Thus, a further review of theories and ecological factors related to substance use relapse would shed light on the mechanisms implicated in addiction recovery among Latinas/os.

Theories and Ecological Factors Implicated in Substance Abuse Recovery

A number of approaches have been developed to explain the etiology of substance abuse in the general population (Johnson, 2007). Studies on Social Ecology (Bronfenbrenner, 1979; Moos, 1973), Social Disorganization (Elliot et al., 1996; Shawn & MacKay, 1942), Social Control (Hirschi, 1969) argue that substance abuse can be partially explained as a response to socially disorganized environments, which in turn impact collective efficacy to prevent substance abuse behavior (Moss, 2007).

During the past two decades, research in neighborhood effects has focused on examining the mechanisms that directly or indirectly influence the contribution of the environment on recovery (See Joe, Simpson, & Broome, 1998). Recently, more attention has been given to environmental factors concerning treatment outcomes (Jacobson, 2004). A growing body of research indicates that both

environmental and social characteristics may influence an individual's behaviors that lead to relapse (Boardman, Finch, Ellison, Williams, & Jackson, 2001; Jason et al., 2013; Stahler et al., 2007). Higher rates of unsuccessful recovery are associated with high-stress levels, lack of access to resources, social disorganization, and substance-using peers (Sloboda, Glantz, & Tarter, 2012). Conversely, social support from non-substance users (Wasserman, Stewart, & Delucchi, 2001), lower stress levels, better quality of life, and more stable environments contribute to substance use cessation (DiClemente, Doyle, & Donovan, 2009; Jacobson, 2004).

Neighborhood-level psychological factors associated with alcohol and substance use relapse include lack of access to mental health services and social support systems, limited access to reliable employment, community violence, harsher living conditions, and discrimination (Williams & Latkin, 2007). Other ecological factors related to substance use relapse are the paucity of resources that facilitate everyday tasks: grocery stores, retail establishments, and health care facilities may contribute to relapse by increasing the burden of “daily hassles” on residents (Jacobson, 2004). Additionally, greater availability of liquor stores and drug markets in disadvantaged areas (Mendoza, Conrow, Baldwin, & Booth, 2013) may expose individuals to environmental triggers for relapse in that it increases availability and the likelihood of alcohol and drug use (Jacobson et al., 2007).

A few studies have explored individual and environmental factors in relation to alcohol and drug relapse. In a study conducted on 180 individuals who

complete SAT, researchers found that two years after treatment completion, participation in leisure activities with substance abusers, need for resources (e.g., employment, childcare, healthcare), and low self-efficacy contributed to alcohol and drug relapse (Walton, Blow, Bingham, & Chermack, 2003). Notably, lack of resources was the most significant predictor of alcohol and drug relapse among low-income ethnic minorities. In the same vein, Boardman and colleagues (2001) found that contextual factors predicted drug use even after controlling for stress levels, resources, and demographics. These results highlight the need for supportive and stable alcohol and drug-free environments where individuals who complete SAT can continue their recovery process. **Theories and Ecological Factors Implicated in Substance Abuse Recovery on Latinas/os**

The extant literature on substance abuse prevention on Latinas/os has been grounded on classic theories, including problem behavior theory (Glantz et al., 2002), polydrug use (Galif & Newcomb, 1999), the multiple risk factor model (Ellickson & Morton, 1999), and the stages of change framework (Prochaska, DiClemente, & Norcross, 1992). Constant efforts to explore substance abuse recovery process have led prevention researchers to introduce new theories or concepts to explain better unique factors impacting this population (Castro et al., 2006). Among these are the following: orthogonal identification (Oetting & Beauvais, 1987), differential acculturation (Martinez, 2006; Szapocznik & Kurnines, 1980), ecodevelopmental (Szapocznik & Coastworth, 1999), and segmented assimilation theories (Portes & Rumbaut, 2001).

Following an ecological approach, prevention science aims to explore proximal factors (i.e., house environment, social support) and distal factors (i.e., cultural environment, resources) that influence Latinas/os' substance use behavior (Bachman et al., 2002; Castro et al., 2006). The social context (i.e., governmental policies, attitudes of native populations, social support, community resources) in which Latinas/os are immersed influence attitudes toward the U.S. mainstream culture, which in turn inform behaviors (Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005). This process is better described as acculturation or a continuous adaptation process in which individuals from one culture are in contact with a host culture (Salabarria-Pena et al., 2001).

The study of acculturation concerning substance abuse behavior is complex given the heterogeneity of the Latina/o population (Szapocznik, Prado, Burlew, Williams, & Santiesteban, 2007; Wallace, Pomery, Latimer, Martinez, & Salovey, 2010). Although the use of cultural practices (i.e., language, behaviors) has been widely explored among Latinas/os (Lopez-Class et al., 2011), substance abuse research needs to consider the influence of psychological acculturation to understand changes in substance use patterns (Cuellar, Arnold, & Gonzalez, 1995). The following review of acculturation theories will serve to illustrate the relevance of this phenomenon on the investigation of substance use recovery among Latinas/os.

Theories in Acculturation Research

Unidimensional Approach

A theory is defined in social sciences as a description of a systematic set of the causal laws that govern social phenomena (Schwandt, 2007). Since the 1930's, research on acculturation has examined the dynamics involving individuals from different cultural backgrounds and the subsequent acquisition of social norms (See Redfield, Linton, & Herskovits, 1936). Early studies on acculturation adopted a unidimensional approach, assuming that non-dominant individuals will surrender their cultural tradition and norms to endorse the norms and values of the dominant culture (Gordon, 1964). Specifically, this approach posited that immigrants would inexorably be absorbed into the *dominant* culture, in a unilinear, unidimensional process. Gordon based his unidimensional theory on centrality of structural assimilation: "Once structural assimilation has occurred, either simultaneously with or subsequent to acculturation, all of the other types of assimilation will naturally follow" (Gordon, 1964, p.80-81).

A cross-cultural psychology article revealed that third generation European immigrants had identity problems and mourned the loss of their grandparents' culture (McGoldrick et al. 1983). This article is evidence that assimilation as a theory may be problematic even when it apparently seems to be successful (Dominguez & Maya-Jariego, 2008). Another criticism of the unidimensional approach is that an unidimensional approach promoted systemic oppression enacted by the dominant culture by devaluating attributions and values of cultures deemed inferior and by excluding them from participation in society as

a whole (Dominelli, 2002). Besides, by normalizing the notion of dominant values and norms, this theory tacitly ascribes individuals endorsing other cultural values to a subordinate status, fostering cultural alienation (Freeman, 2006).

Bidimensional Approach

Inspired by cross-cultural psychology, particularly by cultural identity frameworks, the bidimensional acculturation theory (Phinney, 1990) posits that individuals develop a new identity concerning their cultures of origin. Changes at the individual level include alterations in the individual's attitudes toward his/her cultural identity and the process of acculturation (Phinney, 2003). Expanding on the same notion, Berry proposed that acculturation is "The dual process of cultural and psychological change that takes place as a result of contact between two cultural groups and their individual members" (Berry, 2005, p. 698). Berry's description of cultural changes refers to societal changes, including changes in traditions and norms.

The bidimensional model proposes four possible categories to explain the process of acculturation: a) Integration, or the preservation of the home cultural values and norms while acquiring values and behaviors endorsed by the host culture; b) Assimilation, or the adaptation of cultural traditions and norms promoted by the host culture; c) Separation, or when individuals and groups avoid interacting with individuals from the host culture to maintain cultural traditions and social norms; and d) marginalization, or when immigrant/minority individuals are rejected by their cultural group and are excluded from participating in society, losing cultural values and traditions (Berry, Phinney, Sam, & Vedder, 2006).

Thus, the level of adaptation to the host culture has implications on the individual's well-being and social skills essential to operate in a new society (Berry et al., 2006). It is noted that the bidimensional framework does not assume that having more contact with the host culture and participation in activities that involve both groups may lead to the integration category (Chirkov, 2009).

Critical Acculturation

Some acculturation theorists have criticized the bidimensional framework for failing to include aspects that are relevant to the acculturation process (Chirkov, 2009; Lopez-Class, Castro, & Ramirez, 2011). Berry's four categories of acculturative change has been criticized, suggesting that it ignores the perceptual cognitive, social, and emotional processes that influence the context and the form in which acculturation unfolds (Rudmin & Ahmadzadeh, 2001). Particularly, one of the criticisms is the reductionist focus on how well immigrant/minority individuals contend with their adaptation to a new culture. The changes to what immigrants are exposed may be extreme when the new cultural environment consists of most unfamiliar social conventions (Farver, Narang, & Bhadha, 2002). Two studies employed clustering methods to test out Berry's four categories of acculturation and found small to nonexistent marginalization groups (Schwartz & Zamboanga, 2008; Unger et al., 2007). Berry admits that this framework does not encompass all the variations that occur during the acculturation process nor does acknowledge the dynamic process of acculturation (Berry, 2009). Additionally, Berry's definition has been criticized for its universalist approach, which denies historical, political, and social

inequalities that immigrants and their immediate descendants endure living in a host culture (Bhatia & Ram, 2001). Although the use of this model has proved useful to assess the current level of acculturation in diverse immigrants/minority individuals, it does not capture the process through which individuals achieve a bicultural orientation (Ngo, 2008).

In recent years, acculturation research has focused on psychological acculturation (Berry, 1994), or the changes that take place in the individual as a result of the confluence between the host and the traditional cultural environments (Rudmin & Ahmadzadeh, 2001). At the individual level, there is an increase of knowledge and understanding of the host culture's cultural practices, values, attitudes, and behaviors (e.g., language, music, and food). By the same token, individuals may become more (or less) identified with their traditional culture and more (or less) identified with the U.S. mainstream culture (Tropp, Erkut, Coll, Alarcon, & Vazquez Garcia, 1999). The individuals' cultural perception is shaped by political, economic, and social contexts to which they have been exposed (Castro, Marsiglia, Kulis, & Kellison, 2010) influence how they would adapt to a new environment (Cabassa, 2003), a multi-dimensional approach is needed to examine individuals' cultural orientation.

Multidimensional Acculturation

Recently, acculturation theorists have called for the use of a broader conceptualization of acculturation to account for changes occurring across dimensions (Lopez-Class et al., 2011). Changes in acculturation dimensions are influenced by perceptions about the community in which individuals live, social

interactions with peers, and resources facilitating the adaptation process (Pasick et al., 2009). The process of acculturation involves a reflective and comparative cognitive examination of the frame of references and meanings about the world, others, and self that exist in the individual's cultural community and the one discovered in a new cultural community (Chirkov, 2009). Thus, opposed to a group-level definition, Chirkov defines acculturation as “the process that is executed by an individual (it is not a process that happens to an individual) after meeting and entering a cultural community that is different from the cultural community where he or she was initially socialized” (Chirkov, 2009, p. 178). This process emerges within the context of interactions, both physical and symbolic, with the members of the home and host cultural communities. Thus, acculturation research needs to understand the dynamics, mechanics, and conditions that support/hinder the process of integration into a host culture (Wandersman & Nation, 1998).

Understanding the individual's attitudes toward acculturation is essential when researching Latina/o immigrants and their offspring (Wallace, Pomery, Latimer, Martinez, & Salovey, 2010). Existing literature on segmented assimilation has identified several factors that affect the individual’s acculturation process (Portes & Rumbaut, 2001). Segmented assimilation has been defined as the various process of cultural integration into the U.S. mainstream society (i.e., adoption of attitudes, values, and behaviors) that varies across individuals and groups (Abraido-Lanza, Armbrister, & Florez, 2006; Cabassa, 2003; Thomson & Hoffman-Goetz, 2009). First, exposure to the host culture varies among

immigrants. Some were brought to the host country as young children and are in many ways similar to second-generation individuals. Others migrate to the host country as youth or adults, facing discrimination and disdain for their foreign accents (Yoo, Gee, & Takeuchi, 2009). Among adults, middle-age adults (i.e., 36-55 years) experience greater difficulty in adopting social norms and values of the host culture (Schwartz, Pantin, Sullivan, Prado, & Szapocznik, 2006). However, ethnology challenges related to acculturation may be greater for non-White immigrants and their immediate descendants, who may endure covert and overt hostility rejection from members of the host culture (Portes & Rumbaut, 2001). The aforementioned challenges may lead to *reactive ethnicity* or hold more strongly onto cultural values and norms as a reaction against what is deemed as an imposition from the host culture (Rumbaut, 2008). In sum, exposure to unfavorable contextual factors (i.e., anti-immigrant sentiment, lack of occupational and academic opportunities, low-resource neighborhoods) may decisively impact the acculturation process among Latinas/os (Suarez-Orozco, Suarez-Orozco, & Todorova, 2008).

Notably, the role of contextual factors has become more prominent in theories of acculturation (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). A tenet of the acculturation process is that individuals choose which cultural elements to retain or discard and what social norms to acquire or reject based on contextual and demographic factors (Huynh, Nguyen, & Benet-Martinez, 2011). These changes in social behavior may be greater in low-resource communities where lack of social cohesion and deviant peer influence is more prevalent

(Jacobson, 2004). In a study of acculturative change using Latina/o parents, four groups were identified: a) enculturative change or a decrease in acculturation and increased in Latina/o culture; b) no change in acculturation; c) small increase in the adoption of U.S. mainstream culture (acculturation); and d) significant adoption of U.S. mainstream culture (large acculturative change) (Castro et al., 2011). The characteristics above illustrate the need of redefining acculturation as a multidimensional construct, as it involves changes in health-related behaviors, perceptions/values, and interpersonal relationships that occur within unique contextual factors (Lopez-Class et al., 2011).

Acculturative changes in Latinas/os are influenced by contextual factors, including the cultural environment, social networks, the length of stay in the U.S. and resources available in the community (Pasick et al., 2009). Of relevance is the influence of ethnic enclaves in the acculturation process. Ethnic enclaves are characterized by the presence of ethnic foods, grocery stores selling goods from the home country, the use of both Spanish and English languages, and the endorsement of cultural practices that influence the acculturation process (Schwartz, Pantin, Sullivan, Prado, & Szapocznik, 2006). This type of environment facilitates interactions with individuals from non-Latina/o background, promotes family cohesion, and reduced risky behaviors (Bacallao & Smokowski, 2009).

Acculturation as a Health Risk or a Protective factor

Acculturation is a dynamic process that may lead to both, positive and negative outcomes. On the one hand, mounting evidence indicates that higher

levels of acculturation are associated with increased substance abuse (i.e., high rates of alcohol, tobacco, and drug use), and poor physical (i.e., obesity) and mental health (i.e., anxiety, depression) (Abraido-Lanza, Chao, & Florez, 2005; Alegria et al., 2008; Lara et al., 2005). On the other hand, acculturation is also associated with healthy behaviors (e.g., healthy diet, physical exercise) and life satisfaction (e.g., better employment, education, access to health insurance) (Castro, Marsiglia, Kulis, & Kellison, 2010). However, results from studies examining the association between acculturation and risk behaviors are inconsistent (Lopez-Class, Castro, & Ramirez, 2011; Vega, Rodriguez, & Gruskin, 2009). The mixed results may be due to differences in conceptualization and psychometric measures employed to assess acculturation (Thomson & Hofman-Goetz, 2009). Discrepancies in results may also suggest that acculturation trajectories may operate differently among Latina/o sub-groups (Abraido-Lanza et al., 2006).

Generational Status. Extant literature indicates that Latina/o immigrants are more likely to have lower acculturation with the U.S. mainstream culture and low English proficiency; low educational attainment; fewer occupational opportunities; and face family separation and low social support; which, in turn are associated with substance abuse (Caetano, Ramisetty-Mikler, Vaeh, & Harris, 2007). Conversely, U. S. mainland-born Latinas/os are likely to be more affiliated with the U.S. mainstream culture, speak English, endorse nontraditional family values and engage more in substance use than their immigrant counterparts

(Alegria et al., 2006; Kaplan, Erickson, & Juarez-Reyes, 2002; Samaniego & Gonzalez, 1999).

The Immigrant Paradox

Another aspect that deserves consideration is the immigrant paradox (Suarez-Orozco et al., 2008; Vega et al., 1998). Mounting evidence supports the immigrant paradigm indicating that the more years Latina/o immigrants spent in the U.S., the more they resemble their U.S. born counterparts regarding substance abuse behavior (Alegria et al., 2007; Vega et al., 1998). By the same token, findings from several studies indicate that U.S. born Latinas/os have higher rates of substance use than Latina/o immigrants (Alegria et al., 2006; Maldonado-Molina, Reingle, Jennings, & Prado, 2011; Farley, Galves, Dickinson, & Perez, 2005; Pena et al., 2008; Prado, et al., 2008). However, most studies examining the immigrant paradox measured acculturation using unidimensional markers including country of origin (Corral & Landrine, 2008), the length of stay in the U. S. (Alegria et al., 2007), and language (Caetano, Ramisetty-Mikler, Wallisch, McGrath, & Spence, 2008). The use of multidimensional models may shed light on the acculturation dimensions (.e., cultural practices) that present risk or protective factors for health-related behaviors (Abraido-Lanza et al., 2006).

For Latinas/os, the cultural clash signified by the differences in values and social norms that prevent them from adapting successfully to the host culture, within a cultural environment, may lead to different behavioral consequences (Schwartz et al., 2010). In an attempt to address the immigrant paradox, the role of ethnicity, and the context of reception, Schwartz and colleagues (2010)

proposed a multidimensional approach. These theorists reconceptualized the acculturation construct by including not only immigrants but also their immediate descendants (e.g., second-generation). Then, acculturation is defined as "the confluence among heritage-cultural and receiving-cultural practices, values, and identities" (Schwartz et al., 2010, p. 237). The multidimensional approach proposes an examination of the social practices, values, and identifications of both, home and host culture communities (see Figure 2). These processes may fluctuate in function of the interaction individual-environment (Schwartz et al., 2010). Some of the advantages of this theoretical approach are the following: a) acknowledges that associations between acculturation indicators and behavioral outcomes (i.e., substance abuse) may vary based on the context of reception; b) the examination of multiple dimensions (i.e., attitudes, behaviors) shed light on the aspects that are more salient for specific groups (i.e., immigrants, U. S. born individuals); and c) this approach has the potential to render more exploratory power than the simplistic unidimensional acculturation models (Chirkov, 2009).

Methodological Approach to Acculturation

Research on acculturation often employs an explanatory approach based on quantification and measurement of various acculturation-related variables (e.g., cultural identity, language proficiency, psychological adaptation). This methodology attempts to test theories or develop theories to predict outcomes related to acculturation through experimentation, questionnaires, and statistical analyses (Arends-Toth & van de Vijver, 2006). However, competing acculturation theories lead to a lack of consensus on how such complex construct is

operationalized. Consequently, generalization of findings becomes problematic as some of the psychometric instruments employed measure only aspects of the construct or use proxies of acculturation (Schwartz et al., 2010).

On a meta-analysis of acculturation studies, 43% (18 articles) of the selected studies the definition of acculturation included the words “contact of two or more cultures,” “mutual influences,” “and “changes occur over time at the individual and group level.” Subsequently, in 14% of the articles (6 articles) acculturation was defined as “adaptation to the host culture,” and in 10% of the articles (4 articles) acculturation was defined as “the interaction of the strategies employed by immigrants and the attitude of the host culture” (Chirkov, 2009b). It was noted that most definitions only considered acculturation on a group level and failed to explicate the mechanisms through which acculturation operates at the individual level. The understanding of acculturation as a process that can promote personal growth and individual development is not addressed (Rudmin, Tardif-Williams & Fisher, 2009). Therefore, most definitions of acculturation do not acknowledge the individual nature of this phenomenon, nor do they provide some explanation about the acculturation process (Schonpflug, 1997).

One of the obstacles to test theories of acculturation is the lack of reliable psychometric instruments to assess multiple aspects of such complex phenomenon. Most measures focus on measuring specific constructs that are related to acculturation including language, cultural values, daily living habits, and generational status (Zane & Mak, 2005). When these measures are used in isolation, research may overlook fundamental aspects of acculturation (Unger et

al., 2007). Moreover, studies that explore acculturation using a single-construct measure would mask acculturation issues that may be relevant to particular groups of individuals who live in specific contexts of reception. Let alone that a single-construct measure fails to accurately describe the acculturation process (Schwartz et al., 2010).

Another aspect is the amount of acculturation studies that focus on cultural aspects (i.e., language, generational status) (Berry et al., 2006; Zamboanga, Raffaelli, & Horton, 2006). Given that cultural aspects are at least moderately associated with acculturation, higher order constructs including practices and values/attitudes tend to be overlooked (Sschwartz et al., 2010). A study conducted by Tseng (2004), examining family interdependence in relation to academic adjustments on youth of various cultural backgrounds, found that youth with immigrant parents placed more emphasis on family interdependence. The same study reported that among youth with immigrant parents, family obligation (attitudes) contributed to higher motivation, whereas behavioral demands (behaviors) hinder their academic achievement (Tseng, 2004). These results illustrate the need for adapting a multidimensional framework (i.e., social practices, perceptions) that guide the study of the acculturation process on multiple groups and settings (Schwartz et al., 2010).

Examination of the Acculturation Process

The acculturation process needs to be examined in multiple contexts and within various conditions to elaborate frameworks that allow for the formulation of hypotheses (Chirkov, 2009). Through a comparative cognitive exercise

expressed through language or attitudes, individuals shape their perception of the world, others, and self by adopting characteristics of the host culture and retain or relinquish traits of their traditional background (Chirkov, 2009). This dynamic process is shaped by the attitudes of individuals, which can shape customs and social norms (Bhatia & Ram, 2009; Tardiff-Williams & Fisher, 2009). Therefore, there is a need to explore the role of language, the context of reception, and social networks as facilitators of the acculturation process.

Language. Language is the vehicle through which individuals construct and organize their lives and experiences by learning social norms, rules, and costumes (Chirkov, 2009). If individuals learned and mastered cultural standards and rules in their native language, learning a new set of norms and customs from the host culture may alienate immigrants, undermining their confidence in social control (Chirkov, 2009). In this vein, research indicates that poor social control moderates the association between low acculturation and substance abuse (Pokhrel, Herzog, Sun, Rohrbach, & Sussman, 2013). Although most studies use language as a proxy for acculturation (Cuellar & Maldonado, 1995; Stephenson, 2000), no studies discussed the importance of language in the acculturation process.

Context of Reception. However, language is not the only vehicle through which cultural values and norms are transmitted. The context of reception influences the acculturation process (see Portes & Rumbaut, 2006). The interaction between contextual factors (i.e., services, resources, social support) and acculturation shapes immigrants and their immediate descendants' perception

of the context, leading to health and behavioral outcomes, including substance abuse (Finch & Vega, 2003). Then, the context of reception may determine the extent to which immigrants and their immediate descendants are perceived favorably or unfavorably by members of the host culture (Rohmann, Pionkowski, & Van Randenborgh, 2008). In *ethnic enclaves* or communities with high concentration of immigrants and U.S. mainland-born Latinas/os endorsement of traditional cultural values and norms is observed, sometimes even more vehemently than in their countries of origin (Suarez-Orozco et al., 2008). Particularly, support received from community members is essential for immigrants and minority groups to integrate into the host society (Akhtar & Choi, 2004). Although more acculturation theorists highlight the importance of the context of reception (Johnson, 2007; Schwartz et al., 2010; Williams & Mohammed, 2009), the lack of reliable measures to assess culture of context creates a need for new measures to be developed (Schwartz et al., 2010).

A context of reception that promotes both the home and the host culture allow individuals to converge and synthesize aspects of the two cultures (Benet-Martinez & Haritatos, 2005). Environments that actively promote such unique blend of cultures are characterized by *ethnogenesis* (Flannery, Reise, & Yu, 2001). Several studies indicate that bicultural individuals are more likely to adapt to both cultural schemas when needed while reporting lower psychological distress and higher self-esteem than those less acculturated (Chen, Benet-Martinez, & Harris Bond, 2008). Although the benefits of living in an inviting

context of reception are patent, it remains unclear whether *ethnogenesis* may lead to other positive behavioral outcomes, such as substance use recovery.

Treatment ecology studies also illustrate the importance of stable and supportive context of reception for recovery (Jacobson, 2004). In a sample of former substance abusers, Finney and Moss (1991) found that individuals who returned to more stable environments (i.e., more cohesive and well-organized families) showed better outcomes at 2-year and 10-year follow-up. These researchers also found evidence that lifetime contextual factors are as predictive of treatment outcome as the sociodemographic characteristics and levels of functioning of individuals at intake (Finney & Moos, 1991). Therefore, further examination of the social network composition concerning substance use abstinence is warranted.

Social Networks. A key factor in the transmission of values and social practices between and within groups are social networks. The role that abstinence-oriented social networks play in promoting prosocial behaviors is critical for recovery individuals to remain sober; particularly for those who live in low-resource neighborhoods. According to the social control theory, strong bonds with family members, religious beliefs, and other norms promoted by traditional society motivate individuals to engage in prosocial behavior and refrain from engaging in substance use (Hirschi, 1969). When social support is weak or absent (e.g., dysfunctional families, friends who promote the use of alcohol or drugs), individuals are less prone to adhere to conventional norms and more likely to engage in alcohol and drug misuse (Moos, 2007). Similarly, the social learning

theory asserts that individuals model substance-use attitudes and behaviors from family members and friends (Bandura, 1999).

One of the approaches to study the role of social networks in substance use recovery is social network analysis (SNA). This method allows researchers to examine social processes and social network characteristics associated with substance use recovery (Humphreys, Mankowski, Moos, & Finney, 1999; Jason, Light, Stevens, & Beers, 2014; Kelly, Stout, Magil, & Tonigan, 2011). Social network analysis has deemed appropriate to address contextual questions in community science (Luke, 2005). SNA may be used with whole or egocentric networks. The egocentric network is a type of network analysis that focuses on one person and describes his or her links to other people. SNA utilizes relational data to represent the frequency, importance, and influence of connections for an individual. This method allows substance abuse prevention researchers (Stevens, Jason, Ram, & Light, 2014) and acculturation researchers Dominguez & Maya-Jariego, 2008) to describe the influence of social networks on behavior, particularly in relation to substance abuse.

One of the characteristics of social networks is that are formed with individuals who share common values and beliefs. Among the social network indices, density and centrality are the most significant aspects that represent the network structure. Studies on the diffusion of information indicate that network density and centrality are linked with faster and more efficient communication (McCarty, 2002; McCarty & Wutich, 2005). Density may facilitate diffusion of information and reinforce specific behaviors endorsed by network members. On

the other hand, network centrality (i.e., networks that have ties directed at one or few members), are more likely to facilitate the implementation of norms through hubs that can disseminate the information fast and efficiently (Valente, Chou, & Pentz, 2007).

The dynamic confluence between immigrants and U. S. mainland-born Latinas/os is one of the key elements in the acquisition of new attitudes and behaviors (Amaro et al., 2005). Dominguez and Maya-Jariego (2008) suggest the use of SNA to assess for differences in the social network structure, particularly frequency of contact, promoted behaviors, and importance of such interactions on Latinas/os. Given the collectivistic orientation of Latina/o cultures, the role of social network analysis takes particular relevance for those affected by the lack of culturally modified substance abuse treatment as well as environmental and psychosocial factors. However, the role that social networks have in the recovery process as well as in the acculturation process of Latinas/os remains largely unexplored.

Communal settings: Where Context of Reception and Recovery Environment Converge

Environmental psychology literature indicates that a particular environment may influence engagement in the recovery process. Several studies found that less urban settings have "restorative qualities" that help individuals to recover from stressful conditions (Kaplan, 1995; Ulrich et al., 1991). It is likely that new environments may reduce the frequency of environmental triggers. By the same token, a qualitative study conducted by Gustafson (2001) challenges the

idea that remaining in one's community is crucial for individual well-being and social cohesion. Gustafson (2001) indicates that living in a new location represent opportunities for personal growth and more opportunities. Although sequelae from neighborhood disadvantage exposure may influence the individual's ability to engage in the recovery process, the advantages of living in a more inviting environment, with community resources, and with less environmental triggers are thought to result in better behavioral outcomes (Jacobson, 2004).

The Oxford House Model

The need for sober and inviting environments where individuals continue their recovery has led to the creation of community-based recovery homes. The Oxford House, inc. is a network of self-run democratic recovery homes (Jason, & Ferrari, 2010). The Oxford House (OH) model was founded in 1975 on the premise that a sober, stable environment is needed for long-term recovery. Therefore residents are allowed to stay as long as they need (Jason, Olson, & Foli, 2008). With more than 2100 houses, OH is the largest self-support recovery program in the United States. The OH model enforces three ground rules among its residents: pay rent and collaborate with the maintenance of the house, no disruptive behavior, and refrain from using alcohol and other drugs (Oxford House Manual, 2008). OHs are located in communities with easy access to public transportation, social services, and employment opportunities (Ferrari, Groh, & Jason, 2009). Unlike halfway houses, the OH model employs a system with standards of governance and member practices (e.g., protocol to accept new residents, assign roles in the house, elections, etc.) within a democratic framework

that promotes equal participation in house matters and home activities (Jason et al., 2008).

One of the main characteristics of the OH model is the emphasis on social support to promote sobriety (Jason et al., 2008). First, Oxford Houses foster a peer-support environment through which residents receive support and mentor other residents (Jason et al., 2008). Besides, house activities including house chores, watching TV, and having cookouts may create a home-like atmosphere among OH residents (Contreras et al., 2012). Second, OH relies on Alcoholic Anonymous (AA) or 12-step recovery programs (i.e., support groups that adhere to 12 guiding principles to help an individual remain sober) to provide house residents with social support outside the house (Oxford House Manual, 2008).

The OH model has been extensively studied concerning a variety of behavioral (i.e., abstinence, sense of community, reduced criminal activity) and economic outcomes (i.e., employment, involvement in the criminal justice system) (Jason et al., 2010). Of note, the majority of the sample was composed of European American (58.4%) and African American (34%) OH residents, while only 4% were of Latino background (Jason et al., 2010). These findings indicate that Latinas/os are underrepresented in OHs, even in states with more presence of Latinos (Jason et al., 2007).

There is growing theoretical and empirical support for cultural integration on interventions as they have proven to render better outcomes (Barrera & Castro, 2010; Joe, Canetto, & Romer, 2008). Particularly for Latinas/os, there is the need for culturally sensitive recovery environments that allow for the endorsement of

cultural characteristics and traditions, beliefs, values, norms, and experiences (Contreras et al., 2012). Literature in cultural adaptation suggest making “surface” modifications in existing interventions to increase receptivity and acceptance of the message through the use of language, people, food, and other cultural practices (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

In an effort to explore the underutilization of OHs by Latinas/os, a qualitative study revealed that some of the reasons were the lack of familiarity with the OH model in the Latino community, concerns for being the only Latina/o resident, and the lack of Spanish-speaking OHs (Alvarez, Jason, Davis, Ferrari, & Olson, 2004). A qualitative study shed light on benefits that Latina/o residents experienced in OH including emotional support, being held accountable by house residents, and mutual help (Alvarez Jason, Davis, Ferrari, & Olson, 2007). Recently a qualitative study conducted in OHs located in Texas revealed that Latina/o OH residents benefited from the democratic and collectivistic approach promoted in OHs (Contreras, Gomez, Lopez-Tamayo, Rodriguez, & Jason, 2016).

Recently, a study using the same data set (Jason et al., 2013) found differences in several outcomes based on house assignment (traditional OH vs. culturally modified OH) at baseline and six-month follow up. Results from the above study found the following: a) significant increases in employment income in both settings, with greater income increase among those assigned to a culturally modified OH; b) a significant decrease in alcohol use over time in both contexts, with marked reductions among those living in a traditional OH; c) reductions in use of illicit drugs and prescribed psychiatric medications were observed in both

settings. Overall, these findings shed light on the impact of OHs on Latinas/os in promoting substance use abstinence and steady housing and employment. However, OHs have not been used to study acculturation process, particularly among Latina/o residents.

Rationale

Multiple roadblocks have impeded the advancement of acculturation theories in relation to substance abuse. First, the lack of consensus on a definition of acculturation has led to multiple operationalizations, limiting replication and generalization of findings in similar populations (Chirkov, 2009). Second, most acculturation literature focuses on behavioral aspects (i.e., language, cultural practices), creating a rather simplistic view of such complex sociocultural construct (Portes & Rumbaut, 2001; Schwartz, Zamboanga, & Jarvis, 2007). Third, the dearth of research testing acculturation models on clinical samples of individuals with substance use disorder limits our understanding of the mechanisms that facilitate acculturation process in recovery settings. The above challenges can be surpassed by examining acculturation dimensions within a particular cultural environment (Locke, 1998).

Given that acculturation is an evolving phenomenon, an integrative approach is needed to understand the variations in changes on cultural practices and attitudinal acculturation concerning substance abuse. However, it is notable the number of studies employing unidimensional or language-based measures that render simplistic explanations of the role of acculturation. More important, the dearth of studies examining theories of acculturation, particularly the

acculturation process in relation to substance use is significant. Studies that test theories of acculturation using a critical lens are needed to expand current notions of acculturation and how these theories can be applied to multiple populations and settings. In fact, the challenge of acculturation theories is to test and replicate studies to inform prevention and intervention programs for specific communities, including Latinas/os in substance use recovery. More important, findings from acculturation research should provide policy makers with a better understanding of the mechanisms, interpersonal dynamics, and environment conditions that impact Latina/o immigrants and their immediate descendants' recovery process from substance abuse.

While the number of Latinas/os in need of substance abuse continues to rise, substance abuse treatment that addresses unique social and cultural needs is necessary. The examination of the context of reception is needed to acknowledge historical, political, and social aspects that impact individuals and their communities (Chirkov, 2009). Besides, exploration of the context of reception is critical for the applicability of acculturation research. Although the lack of reliable psychometric instruments developed to assess the context of reception, semi-structured questionnaires designed to measure experiences in a particular setting, as well as the quality of the relationships may offer some insight on this aspect. Studies on Latinas/os in recovery that explore the context of reception (i.e., treatment setting) would shed light on the characteristics that lead to better outcomes based on acculturation levels and generational status (i.e., immigrant vs. second-generation individuals).

Given the importance of the context of reception in the acculturation process, research should investigate settings that promote *ethnogenesis* as potential recovery environments. Community-based recovery homes, like Oxford Houses emerge as a viable option to explore the acculturation process in a unique environment for several reasons: First, the peer-support process is likely to facilitate the learning of values and social norms needed to remain abstinent (Harvey & Jason, 2011). At the same time, experienced house residents provide mentorship to those who begin their recovery process, which gives more acculturated individuals the ability to share their customs and views with less acculturated individuals and vice versa. The use of guidelines, norms, and house structure not only promotes communication among house residents but also facilitates the acquisition and practice of social norms needed to navigate in the mainstream culture.

Second, the home-like democratic environment allows house residents to endorse their cultural values and practices as long as they respect other residents. The creation of culturally modified community-based recovery homes that permit the use of the Spanish language, or a mix of Spanish and English (e.g., Spanglish) would ensure that Spanish-speaking individuals (i.e., immigrants) fully participate in the house activities. Moreover, the ability to use one's dominant language facilitates verbal and nonverbal expression of cultural values and customs, a key aspect of the acculturation process. This type of setting may facilitate the endorsement of cultural values and traditions among Latinas/os without feeling misunderstood or criticized by others (Contreras et al., 2012).

Third, abstinent-social networks provide house residents with opportunities to engage in substance use-free activities, receive support from other individuals, and even learn about occupational opportunities. The bond developed by individuals who are working toward a common goal, recovery from substance use would facilitate the transmission, acquisition, and reinforcement of norms and practices. According to social network analysis theory, centralized networks have leaders that facilitate transmission, acquisition, and reinforcement of social rules and values needed to remain abstinent. A further examination of changes in social network density and composition would serve to assess the contribution of the number and the support of abstinent-social networks for immigrants and their immediate descendants (Dominguez & Maya- Jariego, 2008).

Overall, community-based recovery homes may provide an inviting environment where individuals from different ethnic groups and acculturation levels converge. The OH model provides an inviting environment that facilitates the transmission, acquisition, and reinforcement of norms and practices needed to integrate into the mainstream society through peer-support and abstinent-social networks. Throughout the establishment of several OHs within a geographic area and the election of the house president and other leadership roles among residents, the OH model promotes a supportive environment and communication among house members (Oxford House Manual, 2008).

Therefore, guided by the multidimensional acculturation (Schwartz et al., 2010) and acculturation dissonance (Bankston, 1998) theories, the aim of the

proposed study was twofold: a) examine a multidimensional acculturation model on a sample of 135 Latinas/os who recently completed SAT. Specifically, the study examined behavioral acculturation (i.e., Latina/o cultural practices, U.S. mainstream cultural practices) as moderator of the association between Latinas/os who completed SAT and days participants used alcohol and drugs in the past six months (baseline), at different levels of attitudinal acculturation (i.e., affiliation of Latina/o culture and/or U.S. mainstream culture), using age as a covariate. Correlations were conducted between acculturation dimensions and acculturation process to examine whether they share explanatory power. The second aim was b) guided by critical acculturation (Chirkov, 2009) and segmented assimilation (Zhou, 1997) theories, explored the acculturation process of 84 Latina/o OH residents assigned to either culturally modified OHs (CMOHs) or traditional OHs. Specifically, data from 6-month follow up assessments were used to explore the role of treatment setting (CMOH vs. traditional OH) as moderator of the associations between 1) length of stay in OH and acculturation dimensions (i.e., behavioral and attitudinal acculturation); 2) length of stay in OH and acculturation processes (i.e., house processes, relationships with other house residents, and social network density and composition); 3) acculturation processes and acculturation dimensions; and 4) acculturation processes and substance use at six-month follow-up. Results from the proposed analyses are expected to provide a better understanding of the acculturation process that takes place parallel to the recovery process.

Statement of Hypotheses

Hypothesis Ia: Based on the multidimensional acculturation and acculturative dissonance approaches, high endorsement of Latina/o cultural practices mediates the association between Latina/o immigrants and days using alcohol in the past six months, and the frequency of alcohol use will increase as Latina/o immigrants endorse more attitudinal acculturation (i.e., identify more with the U.S. mainstream culture).

Hypothesis 1b: Based on the multidimensional acculturation and segmented assimilation theories, high endorsement of U. S. mainstream cultural practices mediates the association between U.S. mainland-born Latinas/os and days participants used drugs in the past six months, and the frequency of drug use will increase as U. S. mainland-born Latinas/os endorse more attitudinal acculturation (i.e., identify more with the U. S. mainstream culture).

Hypothesis II: Using the multidimensional acculturation approach, treatment setting placement (i.e. placement in either traditional OH or CMOH) will moderate the association between length of stay in OH and various acculturation dimensions (i.e., Latina/o cultural practices, U.S. mainstream cultural practices, attitudinal acculturation) at six-month follow-up, after controlling for acculturation dimensions at baseline. Changes in acculturation observed at the six-month follow-up assessment are expected to correlate with acculturation process (measured by self-report of house processes, house environment, and adherence to OH rules).

Research Questions

Research Question I: Acculturation research has indicated that the longer an immigrant resides in the U. S., the more they resemble their U.S.-born counterparts in relation to substance use behavior. Then, in light of the Immigrant Paradox and the acculturative dissonance, what acculturation dimension(s) (i.e., Latina/o cultural practices, U. S. mainstream cultural practices, attitudinal acculturation) is (are) associated with days using alcohol and drugs in the past six months?

Research Question II: Using the segmented assimilation theory, does the length of time in OH promotes the acculturation process of Latina/o OH residents by facilitating the acquisition of social norms and interpersonal skills via house processes and house environment (i.e., relationships with other house residents)? And if so, is acculturation processes moderated by treatment setting (i.e., traditional OH vs. CMOH)?

Research Question III: Does length of stay in OH facilitate the acculturation process on Latina/o OH residents by changes in social network density and composition? And if so, are there differences between traditional OH and CMOH residents?

Research Question IV: Does acculturation process as measured by multiple indicators (i.e., house processes, house environment, and social network density) promote sobriety among participants? And if so, are there any differences observed between traditional OH and CMOH?

CHAPTER II

METHODS

Participants

Participants for this study were part of a larger NIH-funded study that examined community-based recovery homes for Latinas/os in recovery from substance abuse (see Jason et al., 2013). A total of 135 Latinas/os were recruited from multiple community-based organizations (CBOs) and health facilities from a large metropolitan area in the Midwest. Of the 120 participants who were either assigned to a culturally modified (n = 70) or a traditional (n=50) Oxford House, 70% were available for the 6-month follow-up interview. The inclusion criteria for this study were (1) being Latina/o, (2) had successfully participated in a substance abuse treatment program, and (3) had remained abstinent from alcohol and/or illicit substances. Of the 135 participants who completed the baseline assessment, four were excluded for not having completed SAT. After completion of baseline interview, eighteen participants declined to be assigned to an Oxford House. All participants were included in the study despite previous involvement in the criminal justice system or legal status.

Baseline data from 131 Latina/o participants (M_{age} = 36.3; *SD*±10.5), 113 males (86.3%) and 18 females (13.7%) was employed to test hypothesis Ia and Ib. Nearly half of the participants immigrated from Puerto Rico, Mexico, Cuba, Guatemala, and El Salvador (49%), with a mean length of stay of 19.2 years (*SD*±13.71) in the United States. The majority of the participants had alcohol and

substance abuse treatment previously (n = 124), while for seven participants it was their first time completing SAT.

Subsequently, data from 84 participants (M_{age} = 37; *SD*±10.1), 68 males (80%) and 17 Latinas (20%), with a mean length of stay of 80 days in an OH, who completed 6-month follow-up interviews were employed to test hypothesis II and four research questions. Below is a description of the two conditions (Traditional vs. culturally-modified OH) where Latina/o OH participants were assigned.

Traditional Oxford Houses

Based on the guidelines outlined by the Oxford House Manual (2008), Oxford Houses (OHs) are single-sex dwellings, and members are expected to pay monthly rent and assist with chores. OHs are equipped with a functional kitchen, a bathroom, laundry facility, and common areas (i.e., living room, patio) where residents may spend social time and engage in house-related activities including business meetings. House residents usually spend time together during meals, entertainment, weekly house meetings, planned or spontaneous gatherings, and while working together on chores. OH residents provide one another with social support specific to the areas of abstinence, finding employment, and attending treatment and 12-step meetings. The average number of house residents is eight, and usually two share a bedroom. OHs are located in communities with access to public transportation and employment opportunities. Of importance, OH has no prescribed length of stay for residents, and mental health professionals are not involved with the OH model.

OH residents are required to comply with the following rules: pay rent monthly and contribute to the maintenance of the house, abstain from using alcohol and illicit drugs, and avoid disruptive behavior. An important aspect of the OH model is its democratic approach, with each House operating democratically with majority rule (i.e., > 80% approval rate) regarding membership and most other policies. House members elect a president, secretary, treasurer, and comptroller who are responsible for conducting and recording House meetings, keeping financial records, and paying House bills. House members serve for the position they were elected for a 6-month period to avoid status differences. Overall governance occurs at weekly house meetings as well as at monthly chapter meetings. House members are encouraged to address house-related issues at regularly scheduled meetings, ad hoc meetings, or through fines or contracts, which specify desired behaviors and consequences of rule-breaking (Oxford House Manual, 2008).

Culturally-Modified Oxford House

Several culturally-modified OHs (CMOHs) were created to meet the needs of Latina/o OH residents while preserving the governance model that characterizes OH. The following "Surface" modifications (Resnicow et al., 1999) were made to promote an inviting home environment for Latina/o residents: 1) CMOH were composed exclusively of Latina/o residents where both Spanish and English were spoken; 2) through the use of Spanish, house residents could address experiences that may be relevant to the Latina/o culture such as family visits and working toward abstinence from a collectivistic standpoint; 3) the presence of

only Latina/o residents allowed for the endorsement of cultural values (i.e., Familismo, Personalismo, Simpatia, Respeto) and expression of cultural practices (i.e., food, music). Of note, no structural changes were made to OHs. There were three culturally-modified OHs and 26 traditional OHs used to test changes both conditions over a 6-month period. The two male and one female culturally-modified OHs were established for this study.

The present study compared the traditional OH model versus CMOHs, where traditional OHs are ethnically mixed, and English is spoken by house residents, and culturally-modified OHs are composed of Latino residents who either speak English or Spanish or a mixture of both languages.

Setting and Procedures

Recruitment of participants took place from fall 2009 to spring 2012. A bilingual/ bicultural research team was formed to facilitate outreach, recruitment, and assessment of Latina/o participants. Research assistants utilized Internet search engines (i.e., Google, Yahoo) and statewide databases of health services and mental health providers to generate a list of substance treatment programs, hospitals, community-based agencies and churches servicing Latinas/os. The outreach strategy consisted of contacting these sites via phone and email to introduce the Latina/o OH project. A team of OH alumni, two of them Latina/os, worked to establish ties with staff and potential participants at various treatment centers. Recruiters provided information on community-based recovery home options, described the nature of the study to potential participants, and facilitated

the interview process. Potential participants were informed about the possibility to be assigned either to a traditional OH or a culturally modified OH.

The main characteristic of culturally modified OHs was that all house residents were Latina/os. Near substance abuse treatment completion, Latinas/os interested in continuing their recovery in an OH were encouraged to contact the project director or the recruiter. Those interested in the study signed consent forms and were interviewed in their language of preference (i.e., English or Spanish) by a cadre of OH alumni and bicultural/bilingual research assistants. Interviews took place at treatment facilities, a private location within an OH, or at the DePaul Center for Community Research.

Participants were explained the nature, purpose, and goals of the study. Research assistants also explained that participation in the study was entirely voluntary and that did not exclude them from being assigned to an OH. Participants reported about their history of alcohol and substance use, social support, acculturation, employment and involvement in the criminal justice system. Assessments and consent forms were collected after participants were accepted either into a traditional OH or a culturally modified OH. House assignment was often determined by openings available in the Chicago area, if the participant's dominant language was Spanish, he or she was placed in a culturally modified OH or in traditional OHs with at least one Latina/o resident who could speak English. Research assistants contacted participants near or at six months after being placed in an OH to schedule a follow-up interview through telephone calls, letters, emails, social media messages (i.e., Facebook) and house visits. A

total of 84 participants completed the 6-month follow-up interview. Participants received $30 as compensation for their time after completing the baseline interview and the 6-month follow-up interview respectively.

Measures

Demographics

A 24-item demographic questionnaire was used to collect participants' age, gender, country of origin, length of time living in the United States, and treatment setting.

Substance Abuse

The Form-90 (Miller, 1996) was utilized to reconstruct daily alcohol and substance use consumption within a six-month time span. The three primary outcome measures of the Form-90 that we will use are drinks per drinking days, percentage of days abstinent, and total number of days of illicit drug use. Days in which participants reported using alcohol or illicit drugs in the last 90 days were coded with a "1", and days on which participants did not use alcohol or illicit substances were coded with a "0." The Form-90 was translated into Spanish using translation and back-translation procedures by a team that included a professional translator, a psychologist, and a psychology graduate student. The Form-90 had been used in several studies with Hispanic/Latina/o samples to produce valid data (Arroyo, Miller, & Tonigan, 2003; Arroyo, Westerberg, & Tonigan, 1998). For the proposed study, a count index of abstinence from alcohol and illicit substances was computed, with higher scores indicating more alcohol and drug use in the past six months.

Acculturation Measures

Various acculturation dimensions: Latino cultural orientation, U.S. mainstream culture orientation, and perception toward Latino and U.S. mainstream culture were measured using two widely used psychometric instruments. Items from the demographic questionnaire were used to collect data on generational status (i.e., Immigrants vs. U.S. mainland-born) and length of stay in the United States to be used as covariates or moderators. Because of the small sample size at the 6-month follow-up assessment (n = 84), an acculturation composite was calculated to assess changes in acculturation as a result of living in either a traditional OH or a culturally modified OH.

Generational Status. An item from the demographic questionnaire collected data on participants' country of origin. Participants were asked to report their place of birth and were assigned either to the *Immigrant* or *U.S. mainland-born* groups. Puerto Ricans who were born on the island were placed in the Immigrant group. We acknowledge that Puerto Ricans are U. S. citizens by birth. However, given the fact Puerto Rico endorses traditional cultural norms and practices similar to those of other Latin American countries, we determined to group Puerto Ricans born on the island with other Latina/o immigrants.

Behavioral Acculturation. The Bidimensional Acculturation Scale for Hispanics (BAS; Marin & Gamba, 1996) is a 24-item, 4-point Likert-type (1=*low* or *not well* to 4=*high* or *very well*) self-report behavioral measure of social practices conducted either in English and Spanish. Three subscales measure

language use, linguistic proficiency, and use of electronic media subscales in both Spanish and English. An item sample of the language subscale includes "how often do you speak English?" The Hispanic and Non-Hispanic domain scores are derived from the total scale, where scores higher than 2.5 suggest biculturalism. Good to high internal consistency (α = .81 - .97) and high correlation with other behavioral measures of acculturation, such as generation in the U.S. and proportion of life spent in the U.S. are reported (Marin & Gamba, 1996).

Attitudinal Acculturation. The Psychological Acculturation Scale (PAS*;* Tropp, Erkut, Garcia-Coll, Alarcon, & Vazquez-Garcia, 1999) is a 10-item, 9-point Likert-type scale (1=*only with Latina/os* to 9=*only with Anglos*) self-report measure that assesses sense of attachment to and belonging within the U.S. and Hispanic/Latina/o cultures. An item sample includes "with what group of people do you feel you share most of our beliefs and values?" A mean total score is derived from the scale, where a score of 5 indicates bicultural orientation. Both the English and Spanish versions of the PAS have good internal consistency (α = .90 and .83) and correlate with language and cultural preferences, along with percentage of life spent in the U.S. and measures of cultural values (Ghorpade, Lackritz, & Singh, 2004). The PAS has been used with a sample of Mexican Americans, Central Americans, and South Americans and found to be correlated with both the proportion of life spent in the U.S. and measures of cultural values (Ghorpade, Lackritz, & Singh, 2014).

Acculturation Process. The Oxford House Processes Questionnaire, a 31-item semi-structured questionnaire developed by the Oxford House research group, was used to assess OH residents' perception on three main domains: house processes (either in a traditional OH or in a CMOH), adherence to OH policies, and house environment. The 'house processes' and "adherence to OH rules' subscales are each composed of 10 dichotomous items (*yes* =1, *no* = 0). Item samples from the house processes and adherence to OH rules subscale include "in the past six months, have you received advice on a personal problem from another resident of your house?" and "Is there a curfew at your house" respectively. The house environment subscale is a 10-item, 5-point Likert scale (0 = *strongly disagree* to 4= *strongly agree*) that assesses the quality of the house environment. An item sample of the 'house environment' subscale includes "house residents treat each other with dignity and respect." Participants report on the impact of the house processes and relationships on their recovery process using a 5-point Likert scale (0 = *very unhelpful* to 4 = *very helpful*). For participants assigned to a culturally modified Oxford House a set of questions was included to assess participants' perceptions of cultural modifications in their house. For the present study, the sum of 'house processes' and 'adherence to OH rules,' and the mean of 'house environment' were used to examine the acculturation process.

The Important People and Activities Inventory (IPA*;* Clifford & Longabaugh, 1991) was used to examine the composition and density of participants' social network. The IPA examines the impact of social network by asking participants questions about their relationships with significant people.

Participants were asked to list up to 12 people that are important and they had contact within the past six months. Participants also reported the four most important people and the most liked among those listed. An item sample includes "is this person generally supportive of you?" The Important People portion of the scale has demonstrated good internal consistency (α = .80; Longabaugh, Wirtz, Beattie, Noel, & Stout, 1995). The IPA was translated into Spanish by a bilingual-bicultural team composed of a psychologist and three research assistants, who focused on semantic equivalence. For the present study, the total number of important network members and composition of social network was used to measure participants' social network density and composition.

CHAPTER III

RESULTS AND ANALYSES

Demographics. Preliminary analyses, using pairwise deletion were conducted to determine descriptive statistics (N = 135). Of the 135 participants who were interviewed, four were excluded from the analysis for not having completed substance abuse treatment. The final sample used for the model analysis was 131 participants (*n* = 63 immigrant, *n* = 68 U.S. born), with a mean age of 36.15 years (*SD*±10.5). Most participants were males (*n* = 113; 86.3%). Nearly half of the participants immigrated from Mexico, Puerto Rico, and other Central American countries (48.1%), with a mean length of stay of 19.2 years (*SD*±13.71) in the U.S. The majority of the participants had alcohol and substance abuse treatment previously (*n* = 124), while for seven participants it was their first time in treatment. The majority of participants in the present study were recruited from an inpatient substance abuse treatment center (n = 98; 72.6%). Of these, 58 (43%) came from a 28-day residential treatment program administered in Spanish. Means and standard deviations for sociodemographic characteristics can be found in Table 1.

Bivariate correlations were conducted in the variables of interest. Results indicated that being an immigrant was positively correlated with Latina/o cultural practices and negatively correlated with affiliation to the U. S. mainstream culture. Immigrants also were more likely to be male and older than their U. S. born counterparts. With regards to acculturation measures, attitudinal

Table 1

Sociodemographic Characteristics of Latina/o Immigrants and U. S. Mainland-Born Latinas/os

	Latina/o Immigrants (n = 63)	U. S. mainland-Born Latina/os (n = 68)
	M(SD)	M(SD)
Age	39.1(10.9)	33.7(9.4)
Education	10.4(2.9)	11.8(1.8)
	%(n)	%(n)
Sex		
Male	96.8(61)	76.5(52)
Female	3.2(2)	23.5(16)
Marital Status		
Married	6.3(4)	3.0(2)
Separated	22.2(14)	13.4(9)
Divorced	22.2(14)	19.4(13)
Never married	49.2(31)	64.2(43)
Country of Origin		
U. S. born (mainland)		100(67)
Puerto Rico[1]	47.6(30)	
Mexico	41.3(26)	
Cuba	4.8(3)	
El Salvador	3.2(2)	
Guatemala	3.2(2)	
Employment Pattern[2]		
Full-time	49.2(30)	36.9(24)
Part-time	31.1(19)	32.3(21)
Unemployment	19.7(12)	30.8(20)
Substance of Major Problem		
Alcohol	23.8(15)	16.4(11)
Heroin/Opiates/Analgesics	15.9(10)	26.9(18)
Cocaine	12.7(8)	9.0(6)
Cannabis/Amphetamines	7.9(5)	11.9(8)
Alcohol & one or more drugs	31.7(20)	31.3(21)
More than one, not alcohol	7.9(5)	3.0(2)
Prior Substance Abuse Treatment		
No	6.3(4)	4.5(3)
Yes	93.7(59)	95.5(64)
History of Incarceration		
No	25.4(16)	19.4(13)
Yes	74.6(47)	80.6(54)
Legal Status (on Parole/Probation)		
No	77.8(49)	58.2(39)
Yes	22.2(14)	41.8(28)

acculturation was positively correlated with U.S. mainstream cultural practices and negatively correlated with Latina/o cultural practices. Alcohol use in the past six months was positively correlated with Latina/o cultural practices and negatively correlated with U.S. mainstream cultural practices. Subsequently, bivariate correlations were conducted on both, Immigrant and U.S. mainland-born groups. Results indicate that, in the immigrant group, Latina/o cultural practices were negatively correlated with U.S. mainstream cultural practices and affiliation with the U.S. mainstream culture. Being older was negatively correlated with drug use. Conversely, in the U.S. mainland-born group, Latina/o cultural practices were positively correlated with alcohol consumption and negatively correlated with U.S. mainstream cultural practices and with affiliation to the U.S. mainstream culture. Being older was positively correlated with alcohol use.

Independent-samples t-tests were conducted to compare the impact of the study variables on immigrant and U.S. mainland-born Latinos. Results from the t-tests revealed that there was a significant difference in age between the immigrant (M = 39.14, SD = 10.90) and U.S. mainland-born Latinos (M = 33.66, SD = 9.39) groups, $t(129) = 3.09$, $p < .01$. Conversely, there was no significant difference between the immigrant and U.S. mainland-born groups regarding alcohol or drug use in the past six months.

Results for Hypothesis Ia. A conditional process analysis using the PROCESS Macro (Hayes, 2013; model 8) was conducted to analyze Hypothesis Ia, which proposed that high endorsement of Latina/o cultural practices mediate the association between Latina/o immigrants and days using alcohol in the past

Table 2

Correlations for the Variables of Interest (H1)

Measure	1	2	3	4	5	6	7	8
1. Non-Latina/o Cultural practices[1]	--							
2. Latina/o Cultural practices[1]	-.68**	--						
3. Attitudinal Acculturation[2] (PAS)	.48**	-.52**	--					
4. Country of Origin	-.61**	.55**	-.26**	--				
5. Drug Use[3]	-.04	.03	-.08	.04	--			
6. Alcohol Use[3]	-.19*	.26**	-.12	.13	.01	--		
7. Age	-.29**	.29**	-.15	.24**	-.25**	.21*	--	
8. Gender	-.31**	.40**	-.16	.29**	-.08	.16	.24**	--

Note. [1]The Latina/o and Non-Latina/o cultural practices are subscales from the Bidimensional Acculturation Scale (BAS).

[2] Attitudinal acculturation was measured using a 1 to 9 Likert scale, where lower values indicate a preference for Latina/o culture and higher values suggest a preference for the U. S. mainstream culture. Values close to the mean (M = 5) indicate that participants successfully navigate between both cultures.

[3] Days when alcohol and drug were consumed within the past six months.

** p<.01.

* p<05.

Table 3

Correlations for the Immigrant and U. S. mainstream-born groups (H1)

Measure	1	2	3	4	5	6	7
1. U.S. Mainstream Cultural practices[1]	--	-.50**	.05	.12	-.23	-.39**	-.20
2. Latina/o Cultural practices[1]	-.59**	--	-.41**	.03	.28*	.32**	.26*
3. Attitudinal Acculturation (PAS)	.63**	-.56**	--	-.22	-.07	-.11	-.06
4. Drug Use[2]	.01	-.02	.07	--	.08	-.21	-.07
5. Alcohol Use[2]	-.14	.17	-.12	-.07	--	.24*	.19
6. Age	-.14	.05	-.09	-.33**	.14	--	.23
7. Gender	-.25*	.49**	-.20	-.17	.03	.15	--

Note. Correlations for the Immigrant group (n = 62) are above the diagonal; correlations for the U.S. mainland-born group (n = 68) are below the diagonal. [1]The Latina/o and U.S. mainstream cultural practices are subscales from the Bidimensional Acculturation Scale (BAS). [2] Days when alcohol and drug were consumed within the past six months.

** p<.01.

* p<05.

six months, and the frequency of alcohol consumption will increase as Latina/o immigrants endorse more attitudinal acculturation (i.e., identify more with the U.S. mainstream culture). Age and drug use were entered in the model as covariates. Continuous values were standardized before running the analysis.

The PROCESS model 8 allows testing moderated mediation using a type of moderation call first stage and direct effect moderation (Preacher, Rucker, & Hayes, 2007). This approach examines the direct and indirect effect of an independent variable (X) on a dependent variable (Y) through one or more mediators (M) that vary at different values or a moderator (W). The main characteristic of the first stage moderation is that moderates the a-path (indirect effect) and it is labeled as the a3-path. Similarly, moderation of the direct effect path (c-path) in a mediation model is labeled as significant c'3-path.

The use of a dummy coded independent variable allows one to compare orthogonal combinations and provides greater statistical power (Cohen et al., 2003). The interpretation of a conditional process model is recommended to focus on the moderation of the indirect and direct effect of X by W (Hayes, 2012). Thus, it is called conditional process in that the effect of X on Y through M is a function of W (see Figure 1). In other words, the indirect effect of nativity (X) on alcohol use in the past six months (Y) through behavioral acculturation (M1- U.S. mainstream cultural practices, M2 – Latino cultural practices) is a function of participants' attitude toward both Latino and U.S. mainstream culture (W). Therefore, it is conditional (a1+a3W) *b*1 (See Figure 2).

Figure 1

Conceptual Model (PROCESS macro, model 8) for Hypotheses Ia and Ib

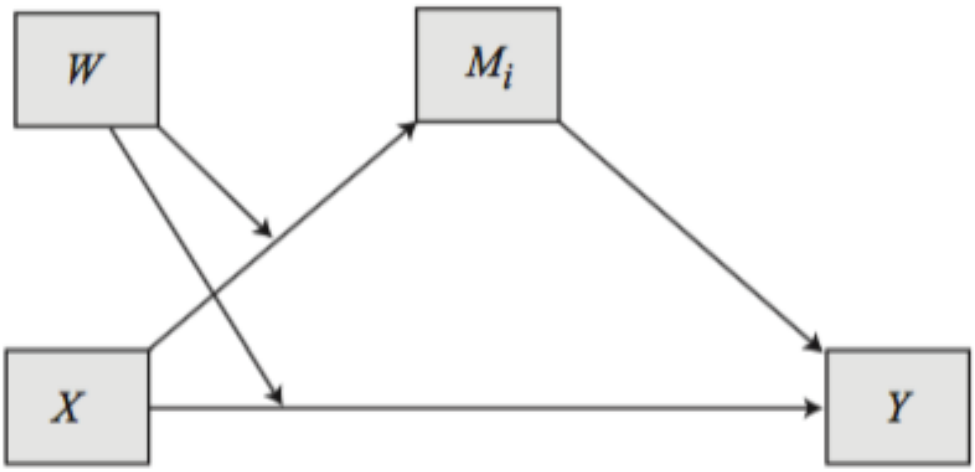
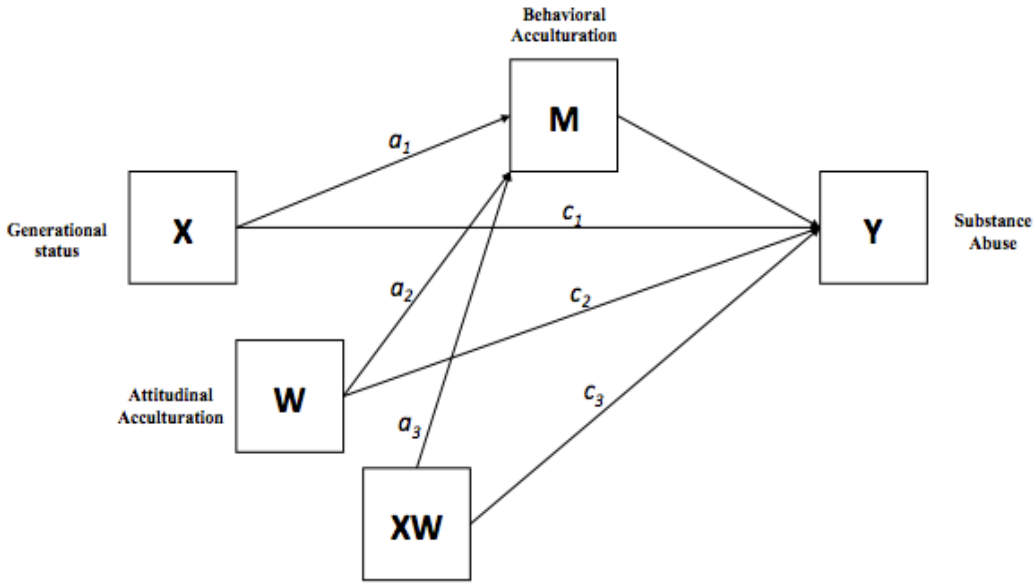


Figure 2

Statistical Diagram of the Conditional Process Model for Hypotheses Ia and Ib



The proposed model was tested, setting bootstrap to 5,000 to calculate indirect effects and create 95% confidence intervals (Hayes, 2013). Evidence of moderation of the indirect effect was found in a statistically significant interaction between Latina/o immigrants and attitudinal acculturation through U.S. mainstream cultural practices, (b = .30, SE = .14, p = <.03), ΔR^2 = .59, F(5, 118) = 33.32, p = <.0001. Thus, the more Latina/o immigrants endorsed higher affiliation to the U.S. mainstream culture, the more days using alcohol in the past six months compared to their U.S. mainland-born counterparts. Conversely, moderation of the indirect effect by Latina/o cultural practices was not statistically significant (p =.77).

It is worthwhile to note that extant methodological research indicates that evidence of an association between independent and dependent variable is not required as a precondition for testing indirect effects (Hayes, 2013). Recent recommendations by Preacher and Hayes (2013) base inference about the indirect effect not on the significance of direct paths, but on a quantification of the indirect effect itself and an asymmetrical bootstrap confidence intervals. Given that the "first stage" of the mediation model (X→M) is moderated, that indicates that the indirect effect is also moderated.

To probe for moderation of an indirect effect the PROCESS macro generates the conditional indirect effect of generational status on days using alcohol in the past six months at values of the moderator attitudinal acculturation. Thus, the conditional indirect effect of the Latina/o immigrant group on alcohol use in the past six months through endorsement of U.S. mainstream cultural

values was significant at the 75th percentile (effect = .142, 95% CI = .011, .263) and 90th percentile (effect = .19, 95% CI = .019, .449) of the moderator attitudinal acculturation. A 95% bootstrap confidence interval for the conditional indirect effect is above zero across the different values of attitudinal acculturation.

Table 4

Model Coefficients for the Conditional Process Model for Hypothesis 1a

M (Behavioral Acculturation)					Y (Alcohol use in the past six months)			
		Coeff	SE	P		Coeff	SE	P
X (Country of Origin)	*a1*	.318	.159	.04	*c'*	-.052	.242	.831
M1 (U.S. mainstream cultural practices)		--	--	--	*b*	.256	.137	.060
M2 (Latina/o cultural practices)		--	--	--	c'_2	.036	.157	.817
W (Attitudinal acculturation)	*a2*	-.267	.069	<.001	c'_3	.009	.110	.937
XW	*a3*	.298	.138	.033		-.037	.211	.862
Constant	i_1	-.304	.226	.181	I_2	-.4571	.341	.182

Thus, U.S. mainstream cultural practices mediated the effect of Latina/o immigrants on alcohol use in the past six months only for those who report high and very high endorsement of attitudinal acculturation. The PROCESS macro produces an index of moderated mediation. Results indicate that the indirect effect is significant (effect = .08, 95% bootstrap CI, .001, .184). These findings illustrate that the indirect effect of the Latina/o immigrant group to alcohol use in the past six months through the endorsement of U.S. mainstream cultural practices is a function of the beliefs or attitudes toward the U. S. mainstream culture.

Results for Hypothesis Ib. A series of conditional process models using the PROCESS Macro (Hayes, 2013, model 8) were conducted to analyze Hypothesis Ib, which proposed that U. S. mainland-born Latinas/os who endorse more U. S. mainstream cultural practices will report more days using alcohol and drugs in the past six months, and the strength of the association will increase as they identify more with the U.S. mainstream culture. The proposed model employing alcohol use as the dependent variable was tested following the procedures previously outlined in Hypothesis 1a. Age and days using illicit substances in the past six months were entered in the model as covariates. Evidence of moderation of the indirect effect was found in a statistically significant negative interaction between U.S. mainland-born Latinas/os and attitudinal acculturation, (b = -.66, SE = .11, p = <.0001), ΔR^2 = .68, F(5, 118) = 50.45, p = <.0001. When probing for moderation of the indirect effect of the U.S. mainland-born Latina/o group on alcohol use in the past six months through U.S. mainstream cultural practices was not significant.

Next, a conditional effect model employing days participants used drugs in the past six months was tested following the procedures outlined for Hypothesis 1a. Age and days participants used alcohol in the past six months were entered in the model as covariates. Evidence of moderation of the indirect effect was found in a statistically significant negative interaction between U.S. mainland-born Latinas/os and attitudinal acculturation in relation to drug use in the past six months, (b = -.425, SE = .204, p = <.03), ΔR^2 = .14, F(5, 118) = 3.14, p = .006. Results from the conditional indirect effect indicate that moderation of

Table 5

Model Coefficients for the Conditional Process Model for Hypothesis 1b

M (Behavioral Acculturation)	Y (Drug use in the past six months)

		Coeff	SE	P		Coeff	SE	P
X (Country of Origin)	*a1*	.722	.125	<.001	*c'*	-.079	.234	.206
M1 (U.S. mainstream cultural practices)		--	--	--	*b*	.001	.133	.994
M2 (Latina/o cultural practices)		--	--	--	c'_2	-.196	.152	.206
W (Attitudinal acculturation)	*a2*	.176	.062	.005	c'_3	-.036	.106	.738
XW	*a3*	-.658	.108	<.001		-.425	.204	.039
Constant	i_1	.272	.074	.173	I_2	1.231	.330	<.001

the indirect effect was not significant as the 95% bootstrap confidence intervals contained zero. The PROCESS macro (Hayes, 2013) generates the conditional direct effects of the U.S. mainland-born Latina/o group on drug use in the past six months. Results indicated that it was significant only for those in the 90th percentile, endorsing very high attitude towards the U.S. mainstream culture (effect = -.657, 95% bootstrap CI, -1.294, -.019). Thus, a reduction in days participants used drugs in the past six months was observed only among U.S. mainland-born Latinas/os who endorsed very high affiliation of U.S. mainstream culture.

Results for Hypothesis II. To analyze Hypothesis II, which proposed that treatment setting placement (i.e., placement in either traditional OH or CMOH) moderates the association between length of stay in OH and various

acculturation dimensions at 6-month follow-up after controlling for acculturation dimensions at baseline, a correlation analysis was conducted with the variables of interest. Results indicated that non-Latina/o orientation at baseline was positively correlated with attitudinal acculturation a baseline and negatively correlated with Latina/o orientation at baseline. Similarly, non-Latina/o orientation at the six-month follow-up was positively correlated with attitudinal acculturation and negatively correlated with Latina/o orientation at the six-month follow-up. None of the acculturation measures at both, baseline and six-month follow-up was correlated with length of stay in OH and OH condition (see Table 6).

A series of moderated regression analyses using the PROCESS macro (model 1) was conducted to test treatment setting (i.e., traditional OH vs. culturally modified OH) as a mediator of the association between length of stay in OH and changes in acculturation reported at the six-month follow-up assessment. Acculturation at baseline was used as a covariate (see Figure 3). The PROCESS macro utilizes an ordinary least squares regression-based path analysis approach to estimate moderation models. Some of the advantages of the PROCESS macro include the ability to probe interactions with simple slopes at each of the two values of the dichotomous moderator (i.e., treatment condition), along with a *t* value, standard error, and *p*-value. This feature allows for an easier interpretation of the estimated effects. All estimated effects reported by the PROCESS macro are unstandardized regression coefficients.

Given that the proposed hypothesis aims to test acculturation dimensions separately, multiple moderation analyses were conducted. First, a moderation model regressing Latina/o cultural practices on the length of stay in OH was

Table 6

Correlations for the Variables of Interest for Hypothesis II

Measure	1	2	3	4	5	6	7	8
1. Non-Latino Orientation T1	--							
2. Latino Orientation T1	-.62**	--						
3. Attitudinal Acculturation T1	.34**	-.49**	--					
4. Non-Latino Orientation T2	.93**	-.59**	.37**	--				
5. Latino Orientation T2	-.64**	.91**	-.40**	-.63**	--			
6. Attitudinal Acculturation T2	-.39**	.51**	-.72**	.40**	.49**	--		
7. Length of Stay in OH	.04	.08	.06	.05	.09	.05	--	
8. OH Condition[1]	-.05	.01	.05	-.06	.06	-.01	.07	--

Note. T1= at baseline. T2 = at 6 months.

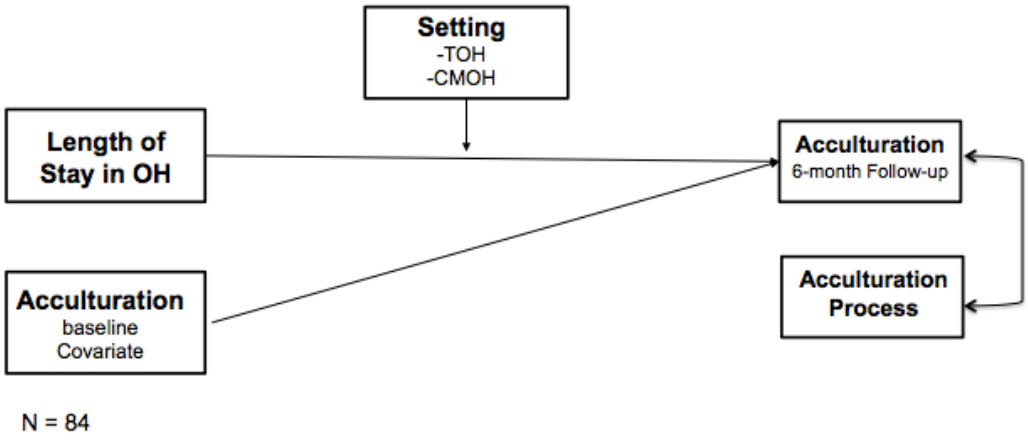
[1] Participants were either placed in a traditional OH or a culturally-modified OH.

** $p<.01$.

* $p<05$.

Figure 3

Analytical Model for Hypothesis II



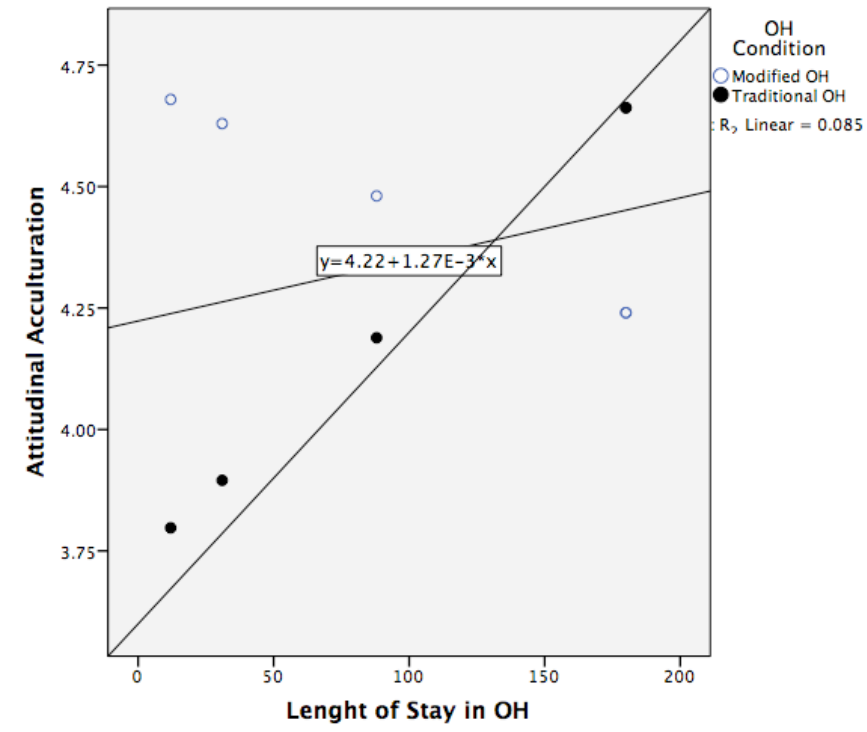
tested, using Latina/o cultural practices at baseline as a covariate. Results from the analysis revealed nonsignificant findings for treatment setting as the moderator, (*b* = .01, *SE* = .001, *p* = *ns*). Next, a similar analysis was conducted where U.S. mainstream cultural practices were regressed on the length of stay in OH. Results from the analysis indicated that the longer participants reside in an OH length of stay in OH did not predict an increase in non-Latina/o cultural practices at six-month follow-up, after controlling for non-Latina/o cultural practices at baseline (*b* = .001, *SE* = .001, *p* = *ns*).

Lastly, the same procedure using attitudinal acculturation at six-month follow-up on the length of stay in OH, using attitudinal acculturation at baseline as a covariate was conducted. Results indicated a marginally significant interaction between length of stay in OH and treatment condition, after controlling for attitudinal acculturation at baseline (*b* = .97, *SE* = .51, *p* = .058). ΔR^2 = .02,

$F(1, 79) = 3.65$, $p = <.059$. The conditional effect of length of stay in OH on attitudinal acculturation was marginally significant on participants assigned to a traditional OH (effect = .005, 95% CI -.0001, .0108). Although the above result was only marginally significant, it is worthwhile to note this finding. Thus, participants who remained longer at traditional OHs experienced an increased identification with the U. S. mainstream culture. That being said, the longer participants resided in traditional OHs, the more identification with the U. S. mainstream culture was endorsed (see Figure 4).

Figure 4

Interaction between Length of Stay in OH and OH condition



Additionally, a bivariate correlation analysis was conducted between various acculturation dimensions at six-month follow-up and various measures of acculturation process (i.e., house process and house environment). Results from the correlation analysis indicated that endorsement of U. S. mainstream cultural practices at six-month follow-up (non-Hispanic domain from the BAS) was positively correlated with house processes (r = .27, p = .01) and house environment (r = .22, p = .04), but not with adherence to OH rules (see Table 7).

Results for Research Question 1. A series of moderated regression analyses using the PROCESS macro (Hayes, 2013; model 1) were conducted to examine this exploratory research question. The PROCESS macro utilizes an ordinary least squares regression-based path analysis approach to estimate moderation (Hayes, 2013). In moderation models, the PROCESS macro probes interactions with simple slopes and regions of significance. Of note, all estimated effects reported by PROCESS are unstandardized regression coefficients.

First, three moderated regression analyses were conducted employing days participants used alcohol in the past six months as the dependent variable. Age was entered as a covariate in each model. Results for the analysis using Latina/o cultural practices as moderator of the association between length of stay in the U.S. and alcohol consumption in the past six months revealed no significant interactions or main effects (p = .46). Similarly, results from the model employing U.S. mainstream cultural practices as the moderator showed no significant interaction or associations between length of stay in the U.S. and alcohol use (p = .73). Lastly, results from the model using attitudinal acculturation as the

Table 7

Correlations for Acculturation Dimensions and Acculturation Process

Measure	1	2	3	4	5	6
1. Latina/o Cultural Practices	--					
2. U.S. Mainstream Cultural practices	-.63**	--				
3. Attitudinal Acculturation	-.49**	.40**	--			
4. House Processes	-.05	.27*	.11	--		
5. House Environment	-.07	.22*	-.03	.52**	--	
6. Adherence to OH Rules	.01	.12	-.12	.26*	.58**	--

Note. The House Processes, House Environment, and Adherence to OH Rules are subscales from the Oxford House Processes Measure.
** $p<.01$.
* $p<05$.

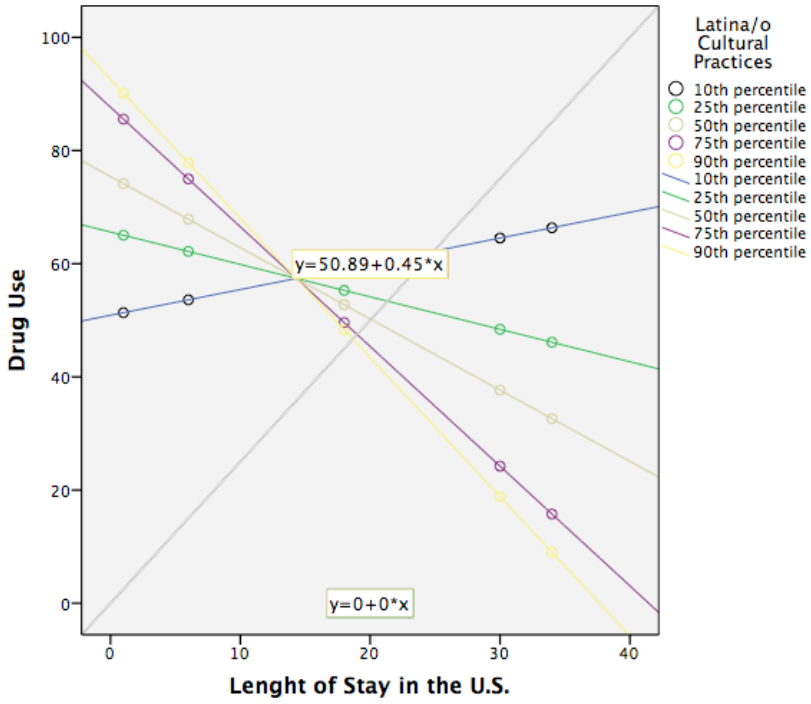
moderator showed no significant interaction or associations between length of stay in the U.S. and alcohol use (p = .57).

Next, three moderated regression analyses were conducted employing drug use in the past six months as the dependent variable. Results from the analysis using Latina/o cultural practices as moderator of the association between length of stay in the U.S. and drug use in the past six months indicated a negative significant interaction between length of stay in the U.S. and Latina/o cultural practices, holding age constant (b = -1.63, SE = .79, p = <.03), ΔR^2 = .25, F(4, 52) = 4.37, p = <.004. To probe this interaction, the PROCESS macro generates the simple slopes at the 10th, 25th, 50th, 75th, and 90th percentiles of the moderator Latina/o cultural practices when estimating the conditional effects of length of stay in the U.S. Thus, for those who endorse moderate (50th percentile = -1.258), high (75th percentile = -2.115), and very high (90th percentile = -2.457) Latina/o cultural practices, the longer Latina/o immigrants live in the U.S., the fewer drug use in the past six months (see Figure 5).

A moderated regression model was conducted with U.S. mainstream cultural practices as moderator of the association between length of stay in the U.S. and days participants used drugs in the past six months. Age was entered as a covariate. Results indicated a negative significant association between length of stay in the U.S. and days participants used drugs in the past six months (b = -5.36, SE = 2.34, p = .02), ΔR^2 = .11, F(3, 57) = 2.41, p = <.05. In other words, the longer Latina/o immigrants live in the U.S.; the fewer days participants consumed drugs in the past six months. Lastly, a moderated regression model was

Figure 5

Interaction Between Length of Stay in the U.S. and Latina/o Cultural Practices on Drug Use in the Past Six Months (baseline)



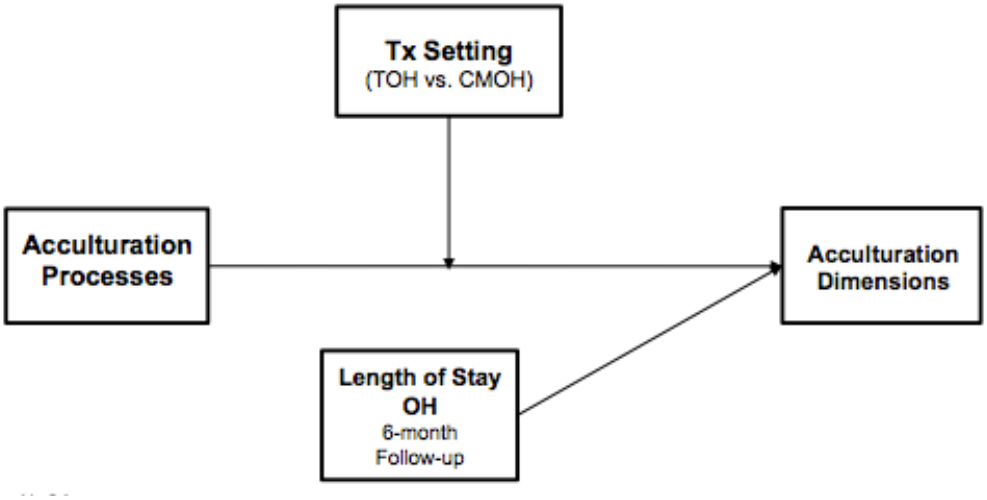
conducted, with attitudinal acculturation as moderator of the association between length of stay in the U.S. and drug use in the past six months. Age was entered as a covariate. Results indicated that there were no significant associations in the above model.

Results for Research Question 2. To examine this exploratory research question, a series of moderation analyses using PROCESS model 1 were conducted to test treatment setting (i.e., traditional OH vs. culturally modified OH) as moderator of the pathways from acculturation process proxy measures (i.e., house process, house environment, adherence to OH rules) and acculturation

dimensions (i.e., Latina/o cultural practices, U.S. mainstream cultural practices, attitudinal acculturation). The length of stay in OH was entered as a covariate (see Figure 6).

Figure 6

Analytic Model for Research Question 2

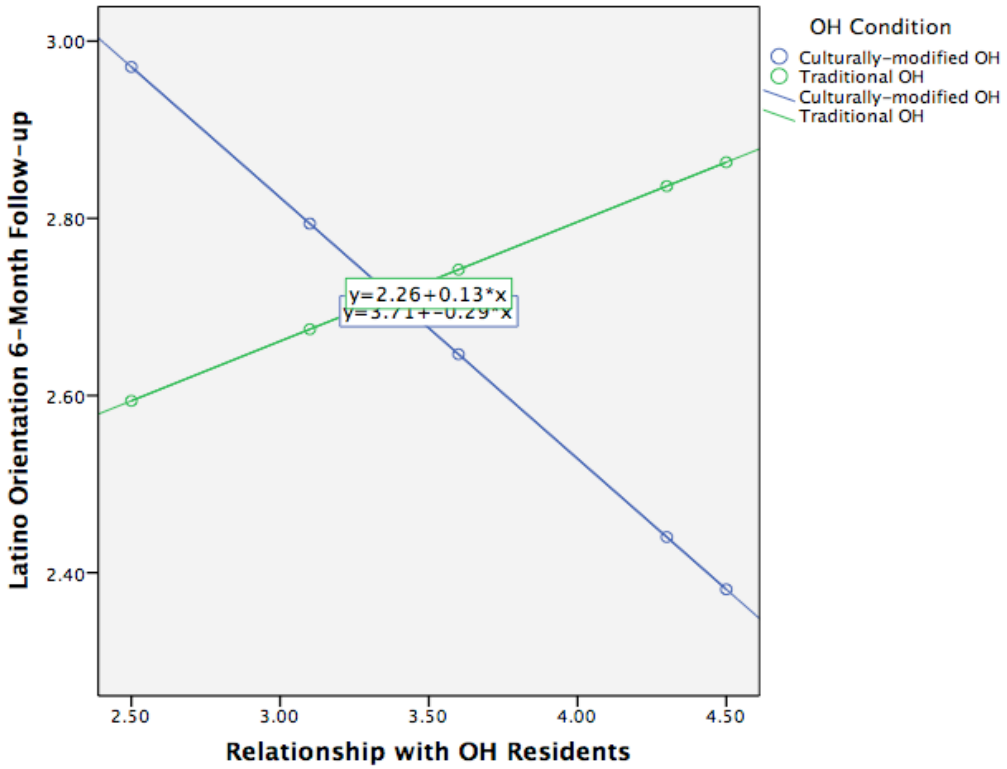


A series of moderation analyses were conducted with treatment setting moderating the path from acculturation processes indicators to Latina/o cultural practices. First, a moderated regression model with house environment as the predictor was tested. Results indicated that the interaction between house environment and treatment condition was negatively statistically significant, (b = -.72, SE = .32, p = .04). ΔR^2 = .07, $F(4, 79) = 1.45$, p = <.04. The conditional effect of house environment on Latina/o cultural practices was negatively statistically significant among participants assigned to a culturally modified OH (effect = -.30, 95% CI -.585, -.005). Thus, there was a reduction in Latina/o cultural practices among participants assigned to a culturally modified OH.

Specifically, as participants engaged in relationships with OH residents, the fewer Latina/o cultural practices were reported among those assigned to a culturally modified OH (see Figure 7).

Figure 7

Interaction between Relationship with OH Residents and Treatment Condition



Similar moderation models as the one described above were conducted using house processes and adherence to OH rules as predictors. Results from the proposed models indicated that there was no evidence of moderation as the interactions between house processes and treatment setting (b = -.01, SE = .05, p = *ns*), and between adherence to OH rules and treatment setting (b = .11, SE = .13, p = *ns*) were not significant.

Next, a series of moderation regression models using the PROCESS macro (Hayes, 2013) model 1 with treatment setting (i.e., traditional OH, culturally modified OH) moderating the association between various acculturation process indicators and U. S. mainstream cultural practices were conducted. First, a model using house environment as the predictor was tested. Results indicate that there was no evidence of moderation as the interaction between house environment and treatment condition was not significant (p = .48). The path from house environment to U.S. mainstream cultural practices was marginally significant, (b = .15, SE = .09, p = .07). Although it was marginally statistically significant this trend indicates that an increase in relationship with OH residents increases the odds of engaging in U.S. mainstream cultural practices or activities.

The same procedure outlined above was used to test treatment setting (i.e., traditional OH, culturally modified OH) as moderator of the associations between house processes and U. S. mainstream cultural practices, and between adherence to OH rules and U. S. mainstream cultural practices respectively. Results from the analyses did not find evidence for moderation as the house process X treatment setting (b = -.001, SE = .03, p = *ns*), and adherence to OH rules X treatment setting (b = -.10, SE = .09, p = *ns*), were not significant. The paths from house processes to U. S. mainstream cultural practices and from adherence to OH rules to U. S. mainstream cultural practices were not significant.

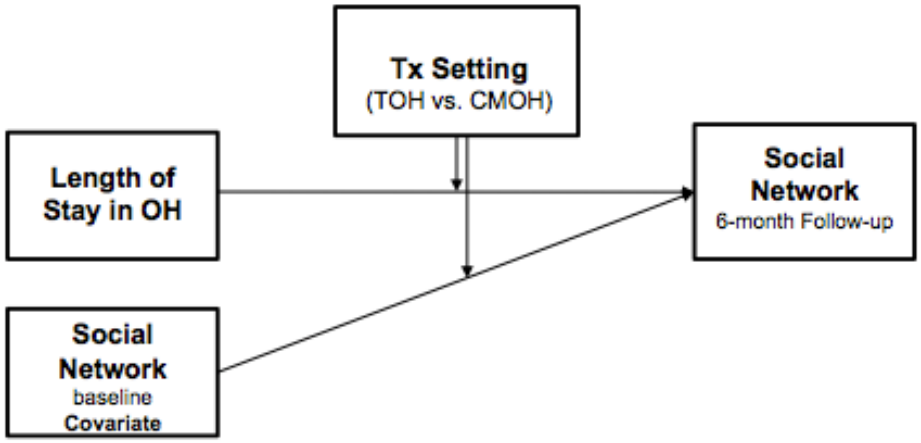
Subsequent moderation analyses using the PROCESS macro (Hayes, 2013) model 1 were conducted to test treatment setting as moderator of the pathways from various acculturation process indicators to attitudinal

acculturation. The length of stay in OH was entered in the model as a covariate. First, a model with treatment setting moderating the association between relationship with OH residents and attitudinal acculturation was tested. Results showed no evidence of moderation as the interaction between relationship with OH residents and treatment setting was not significant (b = .07, SE = .52, p = *ns*). The path from relationship with OH residents to attitudinal acculturation was not significant. Next, a similar model as the described above with house process as the predictor was conducted. Results showed no evidence of moderation as the interaction between house process and treatment setting was not significant (b = -.04, SE = .11, p = *ns*). The path from house processes and treatment setting was not significant. Lastly, a similar model as described above with adherence to OH rules as the predictor was conducted. Results show no evidence of moderation as the interaction between adherence to OH rules and treatment setting was not significant (b = -.05, SE = .31, p = *ns*). The path from adherence to OH rules processes to attitudinal acculturation was not significant.

Results for Research Question 3. To examine this exploratory research question, a series of moderated regression analysis using the PROCESS macro (model 1) were conducted to examine treatment setting (i.e., traditional OH vs. culturally modified OH) as moderator of the association between length of stay and changes in social network density and composition (i.e., number and relationship with important people who oppose or discourage substance use) at 6-month follow-up, after controlling for social network density and composition at baseline (see Figure 8).

Figure 8

Analytical Model for Research Question 3



First, a moderated regression model in which social network density (i.e., number of important people in social network) at six-month follow-up was regressed on the length of stay in OH, after controlling for social network density at baseline. Results from the regression analysis indicated that the interaction between the length of stay in OH and treatment condition was not significant (b = .01, SE = .01, p = *ns*). The path from the length of stay in OH to social network density was not significant.

A series of moderation analyses were conducted to disaggregate the participants' social network composition. A model with number of family members in social network at six-month follow-up as the predictor was conducted, controlling for number of family members at baseline. Results showed no evidence of moderation as the interaction between length of stay in OH and treatment setting was not significant (b = .00, SE = .01, p = *ns*). The path from the length of stay in OH to number of family members in social network at six-month

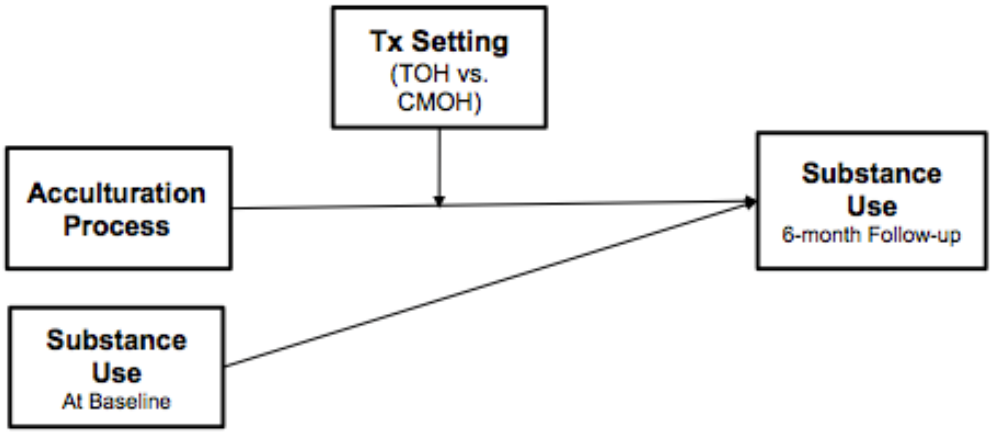
follow-up was not significant. Next, a model with number of friends in social network at six-month follow-up as the predictor was conducted, entering number of friends at baseline as a covariate. Results showed no evidence of moderation as the interaction between length of stay in OH and treatment setting was not significant (b = .01, SE = .01, p = *ns*). The path from length to stay in OH to number of friends in social network at six-month follow-up was not significant. Lastly, a model with number of AA/NA members in social network at six-month follow-up as the predictor was tested, using number of AA/NA members in social network at baseline. Results for the proposed analysis revealed no evidence of moderation as the interaction between length of stay in OH and treatment setting was not significant (b = .01, SE = .01, p = *ns*). The path from the length of stay in OH and number of AA/NA members in social network was not significant.

Results for Research Question 4. To examine this exploratory research question, a series of moderated regression analyses using the PROCESS macro (Hayes, 2013; model 1) were conducted to examine treatment setting (i.e., traditional OH vs. culturally modified OH) as moderator of the association between acculturation process (i.e., house processes, house environment, and social network density) and substance use in the past six months, after controlling for substance use in the past six months at baseline (see Figure 9).

First, a model was conducted with treatment condition moderating the path between house processes and substance use at six-month follow-up. Substance use in the past six months at baseline was entered as a covariate. Results from the model did not support evidence of moderation for the path

Figure 9

Analytical Model for Research Question 4



between house processes and substance abuse at six-month follow-up. However, results found a negative statistical association between house processes and treatment setting (b = -2.67, SE = 1.24, p = .03). Thus, greater values of house processes were observed among participants assigned to culturally modified OHs. Next, a similar analysis was conducted with house environment as the predictor. Results indicated that the cross-product term of house environment and length of stay in OH was not significant for substance use at six-month follow-up, (b = 13.01, SE = 10.75, p = *ns*). The direct effect of house environment on substance use at six-month follow-up was not significant.

Lastly, a model with treatment condition moderating the path between social network density and substance use at six-month follow-up was tested. Substance use in at baseline was entered as a covariate. Results from the moderated regression analysis indicated that the cross-product term of social

network density and treatment setting was not significant for substance use at six-month follow-up, (b = 7.22, SE = 6.45, p = *ns*). The direct effect of social network composition on substance use at six-month follow-up was not significant.

CHAPTER IV

DISCUSSION

The goal of the current study was twofold: a) examine the impact of behavioral and attitudinal acculturation on substance use behavior of 131 Latina/o adults who completed SAT using a multidimensional acculturation approach proposed by Schwartz and colleagues (2010); and b) explore the moderation effect of treatment environment (i.e., traditional OH and culturally modified OH) on changes in acculturation dimensions, acculturation process, and substance use behavior in 84 Latinas/os in recovery from substance abuse disorder.

Three findings emerged from the proposed hypotheses. First, Latina/o immigrants who endorsed more U.S. mainstream cultural practices reported more days using alcohol in the past six months compared to their U.S. mainland-born counterparts, but only those with high and very high affiliation to the U.S. mainstream culture (attitudinal acculturation). Second, reduction in drug use in the past six months was observed only among U.S. mainland-born Latinas/os who endorsed very high affiliation of U.S. mainstream culture. Third, participants who remained longer at traditional OHs experienced an increased identification with the U. S. mainstream culture.

Similarly, four findings emerged from the proposed research questions. First, the longer Latina/o immigrants have lived in the U.S., the fewer drug use in the past six months, particularly among those endorsing moderate, high, and very high Latina/o cultural practices. Second, significant positive correlations between a valid and reliable measure of acculturation (non-Hispanic subscale of the

Bidimensional Acculturation Scale) and two acculturation processes indicators (house processes and house environment subscales of the Oxford House Processes Questionnaire) suggest treatment environment in OHs may facilitate the acculturation process among Latina/o participants. Third, as participants assigned to culturally modified OHs reported more relationships with other OH residents, there was a decrease in Latina/o cultural practices, after controlling for length of stay in OH. Conversely, the pathway from house environment (i.e., interaction with other house residents) and endorsement of U.S. mainstream cultural practices was marginally significant, suggesting that interactions with house residents led to increased endorsement of U. S. mainstream cultural practices. Fourth, results from a moderation analysis revealed that Latina/o house residents who reported increased house processes showed reductions in days using alcohol and drugs in the past six months, after controlling for substance use at baseline. Further discussion of each finding, as well as limitations and suggestions for future study can be found below.

Discussion of Hypothesis Ia: Results indicated that endorsement of U.S. mainstream cultural practices mediated the effect between Latina/o immigrants and days using alcohol in the past six months (baseline), and alcohol consumption increased as Latina/o immigrants endorse high and very high identification with the U.S. mainstream culture. These findings support the inclusion of cultural practices and attitudes in models as moderators and mediators of substance abuse (Castro & Alarcon, 2002). Moreover, results of the analysis support the growing body of research on multidimensional acculturation frameworks (Abraido-Lanza

et al., 2006; Eitle et al., 2009; Castro et al., 2010; Schwartz et al., 2010, 2014) in that it examines simultaneously unique associations between behavioral acculturation and substance use behavior at different values of psychological acculturation aspects (Lopez-Tamayo, Alvarez, & Jason, 2016). The use of the proposed approach showed that results between models using only behavioral acculturation indicators (Castro et al., 2010) and those including behavioral and attitudinal acculturation diverge significantly (Lopez-Tamayo, Alvarez, & Jason, 2016).

Of particular interest are studies indicating the influence of cultural values and attitudes on substance use recovery (Schwartz et al., 2014; Jason, Luna, Alvarez, & Stevens, 2016). These results are consistent with findings of Schwartz and colleagues (2014), suggesting that higher endorsement of U.S. cultural practices was associated with alcohol consumption among Latina/o emerging adults (75% women; 77% U.S.-born). Attitudes represent a cognitive dimension of acculturation that influences individuals' identification with a cultural group. Based on the present findings, the study of several aspects of acculturation by disaggregating substance abuse data by generational status and by alcohol and drug use is useful to explain variations in substance use behavior among Latinas/os.

These results also expand on the growing body of research on segmented assimilation (Castro et al., 2010) that has suggested behavioral acculturation mediates the association between Latina/o immigrants and alcohol use behavior (Eitle, Wahl, & Aranda, 2009; Epstein et al., 1996; Gil et al., 2000; Lara et al.,

2005; Stone & Meyler, 2007; Vega et al., 1998) in that behavioral acculturation is moderated by cultural identification. The unique contribution of this finding is that it is the first time a multidimensional acculturation framework is employed to examine the association between behavioral acculturation and substance use in the past six months through attitudinal acculturation. The use of a well-delineated sub-group (e.g., Latina/o adults in recovery from SUDs) allowed for a better detection where the associations are most salient (Updegraff, K. A., Umana-Taylor, 2010).

Although valuable, most research exploring the complex associations among generational status (i.e., immigrant vs. U.S. mainland-born Latinas/os), acculturation dimensions, and alcohol use behaviors have focused on Latina/o adolescents (Eitle, Gonzalez Wahl, & Aranda, 2009) and recently on adult immigrants (Alegria, Alvarez, & DiMarzio, 2017). For example, studies on a variety of ethnic groups show that Latinas/os and Asian immigrants are more at risk for a number of adverse behaviors than their immigrant counterparts (Gordon-Larsen et al., 2003; Nagasawa et al., 2001). A plausible explanation is that Latina/o immigrants are confronted with acculturative dissonance (Bankston, 1998), or discrepancy between endorsement of Latina/o cultural practices and increasing identification with the U.S. mainstream culture. In other words, alcohol use among Latina/o immigrants increased in function of the dissonance elicited by the endorsement of their cultural practice, which increased as their identification with the U.S. mainstream culture increased.

Acculturative dissonance may be introduced in Latina/o immigrants by alcohol expectancies (Des Rosiers et al., 2012). Drawing on cognitive-affective and social learning conceptualizations of alcohol use, alcohol expectancies are operationalized as cognitive representations about the effects of alcohol use, which are informed by the individual's learning experience and psychological effects of alcohol use (Goldman, Reich, & Darkes, 2006). Given that alcohol use is deemed as culturally accepted among Latina/o cultures, it is plausible that Latina/o immigrants' drinking behavior increased as an attempt to "fit in" the U.S. mainstream culture (Schulenberg & Maggs, 2002). It is also plausible that alcohol use was used to cope with the stressors that come with being part of a minority group navigating between two cultures (Des Rosiers et al., 2012).

As discussed above, these results are consistent with the segmented-assimilation theory (Portes & Rumbaut, 2001), which posits that the longer an immigrant is in contact with the host culture, the more likely is to adopt the host culture's social norms. More important, the segmented-assimilation framework indicates that immigrants acquire certain cultural conventions from the U.S. mainstream culture while maintaining elements of their own culture (Gibson, 1988), and the selection of social norms is facilitated by the family, social networks and the community (Portes & Rumbaut, 2001). Segmented assimilation has examined Latina/os' differing assimilation trajectories among Latina/os, which vary based on the individual's social and human capital (Portes & Rumbaut, 2001; Williams, 2009). As noted in the literature, high rates of alcohol use among Latina/o immigrants (Alegria et al., 2008; Vaughan, Robbins, &

Escobar, 2014; Vega et al., 2009) may be as a result of adopting U.S. social norms toward drinking (Zemore, 2005, 2007). Overall, segmented-assimilation theory illustrates that the acculturation process may result in different ways of cultural adaptation, where some acculturation dimensions develop more than others (Eitle et al., 2009).

Discussion of Hypothesis Ib: Results from the proposed analysis supported moderation of the path between U.S. mainland-born Latinas/os and reduced drug use in the past six months, but only at very high levels of attitudinal acculturation. The above findings expanded on current research on substance use that suggests U.S. mainland-born Latinas/os have greater drug use than their immigrant counterparts (Alegria et al., 2007; Lara et al., 2005) by integrating cultural values into models that better describe potential protective factors (Castro & Alarcon, 2002). The unique contribution of this study is that it represents the first time a model is used to explore behavioral acculturation dimensions as moderators of substance use at different levels of attitudinal acculturation in a clinical sample of Latinas/os in recovery from SUDs.

The results of this analysis are partially consistent with research on segmented assimilation in that U.S. mainland-born individuals are exposed to greater economic and class inequality (Portes, Fernandez-Kelly, Haller, 2005), which, in turn, is associated with greater substance use (Castro et al., 2010). A plausible explanation of the above finding is the role of bicultural identity (Phinney 2005) as a promoter of acculturative dissonance (Bankston, 1998) among U.S. mainland-born Latinas/os. Ethnic identity provides motivation to

engage in activities with others of the same ethnic group (Saylor & Aries, 1999). However, motivation to engage in activities is not sufficient to participate in cultural behaviors (Phinney, 1990). Although the need for a context of reception that allows individuals to converge and synthesize aspects of the two cultures (Benet-Martinez & Haritatos, 2005), U.S. mainland-born Latinas/os may be exposed to neighborhood disadvantage, discrimination, and fewer occupational and educational opportunities that lead to maladaptive coping strategies including drug use.

Neighborhood characteristics, social cohesion, and access to services should be acknowledged as contextual influences on acculturation trajectories (Castro et al., 2010; Lopez-Class et al., 2011), which, in turn, influence the individual's health (Alegria et al., 2006, 2017; Castro et al., 2010). Studies using an ecodevelopmental model of acculturation suggest that context-specific behaviors are critical for the acculturation process of second-generation Latinas/os (Alegria et al., 2009; Bacallao & Smokowski, 2009; Castro et al., 2010; Lopez-Class et al., 2011). Specifically, perceived discrimination (Perez, Fortuna, & Alegria, 2008), structural and social barriers to services and community resources (Karriker-Jaffe et al., 2012) may influence their integration to the U.S. mainstream culture, changing their perception of the host culture (Gee, Ryan, Laflamme, & Holt, 2006; Turner, Lloyd, & Taylor, 2006). Additionally, U.S. mainland-born Latinas/os who live in disadvantaged neighborhoods may be exposed to deviant peers and to adhere to unconventional norms, which may

increase the likelihood of using drugs as a coping mechanism (Caughy, O'Campo, & Mutaner, 2003; Gallardo & Curry, 2009).

Discussion for Hypothesis II. Results from the proposed analyses supported the hypothesis that treatment setting moderated the association between length of stay in OH and attitudinal acculturation at six-month follow-up, controlling for attitudinal acculturation at baseline. This result is a unique contribution to the acculturation literature (Caetano, 1987; Chirkov, 2009; Castro et al., 2010; Lopez-Class et al., 2001) in that it is the first study that examined the contribution of treatment environment (i.e., traditional OH) to changes in identification with the U. S. mainstream culture over time. Although marginally significant, it shows that living with bilingual Latinas/os and non-Latina/o OH residents –mostly European American and African American house residents- facilitated participants' identification with the U.S. mainstream culture. Of note, given the increasing cultural and racial diversity in the U.S., identifying with the U.S. mainstream culture does not imply identifying with the European American cultural mainstream (Alba & Nee, 2006; Portes & Rumbaut, 2006).

Results from the proposed analyses shed light on findings from a recent study conducted by Jason and colleagues (2016) on the same sample of Latina/o OH residents where higher endorsement of collectivism was observed among those assigned to traditional OHs. These results suggest that the house climate cultivated in traditional OH facilitated changes in acculturation domains including values (i.e., collectivism) and attitudes (i.e., identification with the U.S. mainstream culture) among Latina/o participants assigned to traditional OHs.

Based on Schwartz and colleagues' seminal model (2010), acculturation can be disaggregated in terms of dimensions (i.e., multidimensional), domains (practices, values, and identifications), and components (individualistic vs. collectivistic). Although modestly correlated, each acculturation component contributes to describing critical aspects of acculturation (Schwartz et al., 2011). That being said, increases in affiliation to the U.S. mainstream culture and collectivism are not contradictory components, but complementary in the examination of the acculturation process.

These findings are consistent with prior research conducted on Latina/o OH residents who revealed they "blended into the house" within the first weeks (Alvarez et al., 2007). The cultural studies literature has inspired the development of multicultural models where individuals acquire the social norms and conventions of the host culture (i.e., U.S. mainstream culture) while preserving traditional practices and customs (Guo, Suarez-Morales, Schwartz, & Szapocznik, 2009). Consistent with the social learning theory (Bandura, 1988) it is plausible that Latina/o participants assigned to traditional OHs changed their perception about the U.S. mainstream culture by observing non-Latina/o OH residents' cultural practices and partaking in house activities. Moreover, changes in attitudes are observed when individuals’ goals are consistent with the goals of their in-group (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Thus, consistent with the segmented-assimilation theory (Portes & Rumbaut, 2001) and treatment ecology theory (Jacobson, 2004), it is plausible that the house climate in traditional OHs created an inviting environment in which Latina/o participants felt

included. More important, it appears that an inclusive and culturally diverse treatment setting facilitate the acculturation process through participation in house activities.

Positive changes in life satisfaction (Castro et al., 2010) and psychological adjustment (Soriano, Rivera, Williams, Daley, & Reznik, 2004) have been observed among immigrants who maintain their traditional values but also partake in U. S. mainstream cultural practices (Birman & Tran, 2008; Le & Stockdale, 2008). For example, a cluster analysis conducted in 83 first-generation married Chinese mothers indicated that psychologically-behaviorally integrated mothers had more resources to adapt to the mainstream culture (Tahseen & Cheah, 2012). As immigrants' psychological and behavioral acculturation varies across different groups (Triandis, 2001), more research is needed to understand positive and negative outcomes associated with the acculturation process across time.

Results from the correlation analysis indicating that house processes and relationships with OH residents are positively associated with endorsement of U. S. mainstream cultural practices expand on the growing literature on acculturation process (Schwartz et al., 2010, 2014; Warner et al., 2006). Individuals' perception of living in a supportive community (e.g., collective efficacy; Sampson et al., 2005) has been linked to better health outcomes (Kawachi et al., 1999). It is plausible that the egalitarian and supportive environment promoted among OH residents facilitated the adoption of U. S. mainstream cultural practices. Taken together, these results suggest that the same social and physical settings where Latinas/os live may lead to different responses based on their personal experience,

peer support, and community resources (Castro et al., 2010). Today advances in technology and transportation allow Latina/o immigrants and their offspring to maintain social ties in both their country of origin and in the U.S. mainland. Thus, house processes and house environment may, in turn, be used to explore aspects of acculturation largely ignored in acculturation research. Although the convergence shown between acculturation process indicators and a measure of behavioral acculturation is promising, development of more refined measures of acculturation process is needed.

Of note, participants assigned to traditional OHs were both, immigrant and U.S. mainland-born Latinas/os who were bilingual. Given logistic constraints (i.e., issues with availability) a few Spanish-speaking participants were assigned to traditional OHs where there was a bilingual Latina/o resident. The rationale was to facilitate communication of Spanish-speaking participants with non-Latina/o house residents. Then, results from the proposed analysis should be interpreted in light of this limitation.

Discussion for Research Question 1. The findings indicating that the longer Latina/o immigrants live in the U.S., the fewer days participants used drugs in the past six months (baseline), particularly for those who endorse moderate, high, and very high Latina/o cultural practices, shed light on the extent to which Latino cultural practices serve as a protective factor among Latinas/os with SUDs. This result expands on the premise that the longer immigrants live in the U. S., the higher risk to engage in substance use behavior (Alegria et al., 2007; Gil et al., 2000; Suarez-Orozco et al., 2008; Vega et al., 1998) by providing a

more nuanced understanding of the mechanisms through which engagement in cultural practices reduce drug use (Bacio, Mays, & Lau, 2013). To the best of our knowledge, this is the first study that used a clinical sample of Latinas/os who completed SAT to explore the impact of cultural practices on substance abuse behavior. Therefore, caution is suggested when comparing these findings with those obtained from studies conducted on national representative samples (Lara et al., 2005).

The finding is partially supported by studies on acculturation stating it operates on a continuum (Roysicar-Sodowsky & Maestas, 2000), and that changes in acculturation dimensions may occur at different rates (Chung, Kim, & Abreu, 2004; Kang, 2006) based on contextual factors (Eitle et al., 2009). Of importance, the context of reception, experiences of social support and social exclusion, language, and resources available may have influenced the gradual divergence between cultural practices in relation to substance use (Alegria, Alvarez, & DiMarzio, 2017; Castro, Shaibi, & Boehm-Smith, 2009; Castro, Marsiglia, Kulis, & Kellison, 2010). It is also plausible that Latina/o immigrants endured acculturative dissonance as they seek to partake in U. S. mainstream society, but lacked mechanisms or resources (Eitle et al., 2009) that had facilitated the acculturation process (Le & Stockdale, 2008). Although it is beyond the scope of the study, it is plausible that early immigration to the U.S., family conflict, poor ethnic identity development, and a hostile context of reception led a number of Latina/o immigrants to minimally endorse their home cultural practices (Portes & Rumbaut, 2001; Samaniego & Gonzalez, 1999).

Although attitudinal acculturation was not associated with changes in days participants use alcohol or drugs within a six-month period, it is plausible that traditional cultural values may operate at the cognitive level. Therefore, future research should explore traditional cultural values as moderators of the length of stay in the U.S. and substance abuse behavior among Latina/o immigrants. Overall, the literature on the immigrant paradox presents the ongoing dilemma– is the acculturation process beneficial as it promotes the integration of immigrants to the U.S. mainstream society (Portes & Zzhou, 1993), or is detrimental to the mental health of immigrants (Castro et al., 2010). The finding from the present exploratory analysis supports the use of more nuanced approaches that identify the extent to which acculturation dimensions lead to substance use behavior at different levels of contextual factors.

Discussion for Research Question 2. The series of analyses conducted shed light on the directionality of behavioral (i.e., Latina/o and U. S. mainstream cultural practices) and attitudinal acculturation (i.e., affiliation to Latina/o and U.S. mainstream culture) trajectories over time. Participants assigned to a culturally modified OH reduced their engagement in Latina/o cultural practices as they engaged in OH activities. By the same token, house environment promoted the endorsement of U.S. mainstream cultural practices among participants in culturally modified OHs. These results are consistent with findings described in Hypothesis II and partially consistent with the literature on segmented-acculturation (Castro et al., 2010; Eitle et al., 2009) in that acculturation

trajectories can be better explained by the processes associated with increased interaction with more acculturated individuals.

The findings that the house environment (i.e., relationship with other OH residents) promoted in culturally modified OHs facilitated the acculturation process by increasing the endorsement of U. S. mainstream cultural practices (i.e., non-Latina/o subscale of the BAS) being to fill the gap in the limited acculturation process literature (Castro et al., 2010; Portes & Rumbaut, 2001). Research suggests that observable behavioral changes may follow different paths when deemed necessary for socio cultural adaptation to a new cultural environment (Wolfe et al., 2001). Studies on bicultural identity integration have found that cultural blendedness was related to behavioral acculturation among individuals who engaged in cultural practices associated with both cultures (Miramontez, Benet-Martinez, & Nguyen, 2008). In the same vein, bicultural blendedness was found to be correlated with exposure to U.S. mainstream culture (Huynh, 2009). Thus, it is plausible that Latinas/os assigned to a culturally modified OH – a mix of immigrants and U.S. mainland-born Latinas/os, engaged in U.S. mainstream cultural practices promoted by other house members who were more acculturated. In light of these results, treatment setting (culturally modified OHs) plays a preponderant role in the acculturation process of Latinas/os in recovery.

It is also plausible that through engaging in U.S. mainstream cultural practices promoted in culturally-modified OH Latina/o participants increased their cultural capital. The latter construct is defined as the values and norms present

within a community that influence the individual's opportunities, perceptions, and behaviors (Brubaker, 2004). Coleman (1988) posits that cultural capital is a means to an end, or a means by which Latina/o house residents can promote acculturation and sobriety.

In sum, the house environment promoted in culturally modified OHs was found to promote the acculturation process among Latina/o residents. Although it is evident that Latina/o participants are committed to or identified more with one culture, the treatment environment allowed Latina/o participants to navigate between the Latina/o and the U.S. mainstream culture. Particularly, treatment settings with a bicultural approach—where participants endorse both Latina/o and U.S. mainstream cultural practices—appears to be associated with better outcomes, including reduced alcohol and drug use (Bacio et al., 2013; Rosiers et al., 2012). The integration of cultural variables into existing theories and models is critical in the development prevention programs, including substance abuse prevention and treatment (Castro & Alarcon, 2002).

Discussion for Research Question 3. Results from the proposed analyses revealed no evidence of treatment setting as moderator of the association between length of stay in OH and changes in social network density and composition. A plausible explanation for the nonsignificant findings is that changes in social network did occur, but new network members may have replaced previous network members, masking changes over time. It is likely that network members who supported alcohol and drug use had been replaced with individuals working

on their recovery. There is the need for continued research that examines changes in social network size and composition for Latinas/os in recovery.

The consideration of social network density and composition is an efficient tool for studying the individual's level of social cohesion and support (Dominguez & Maya-Jariego, 2012). The focus on relationship enhancement, both qualitative and quantitative, is a shared construct that is linked to both substance abuse recovery and acculturation. Mounting evidence on recovery homes suggests that social cohesion and support (Jason, Stevens, Ferrari, Thomson, & Legler, 2012), and changes in social network size and relationship with other house members (Groh, Jason, Davis, Olson, & Ferrari, 2007) promote substance abuse abstinence and a sense of community among OH residents (Stevens, Jason, Ram, & Light, 2015). By the same token, increases in social support from family and relatives, mainly instrumental support (i.e., help fixing a car) and expressive support (i.e., getting advice from parents or siblings) leads to increased acculturation among Latina women (Vega, Kolody, Valle, & Weir, 1991). Given that the interaction of Latina/o OH participants with their network members has, without question, a large influence on shaping attitudes and behaviors, adapting current measures of social network to capture the acculturation process is warranted.

Discussion for Research Question 4. Results from the proposed analysis revealed that house processes – established OH rules and interpersonal relationships, led to reduced substance abuse at six-month follow-up among participants assigned to both treatment settings. This result is consistent with prior

qualitative studies conducted on Latina/o OH residents (Contreras et al., 2012; Contreras, Gómez, López-Tamayo, Rodriguez, & Jason, 2016) that suggest the democratic and supportive environment fostered in OHs facilitate the recovery process of Latina/o residents. More important, this finding expanded on previous research on recovery houses that indicates OHs reduce relapse by providing structured activities and referrals for additional services for those with severe addiction (Harvey, Jason, & Ferrari, 2016). Although this is a cross-sectional study that cannot establish temporal ordering, this finding is suggestive of the parallel process occurring in Latina/o OH residents.

The unique contribution of this study is that, to the best of our knowledge, it is the first time the association between house processes -a proxy for acculturation process – and substance abuse was explored in a community sample of Latinas/os in recovery from SUDs. Existing acculturation measures (i.e., behavioral, attitudinal, bicultural identity) can only provide a partial explanation of the phenomenon acculturation. Given the influence of treatment environment in changes in substance use behavior, there is the need for measures that capture the nuances of the acculturation process. Taken together, this finding supports the need for studies that focus on the operationalization and measurement of acculturation processes and their use in substance abuse models (Castro & Alarcon, 2002).

Although the above result did not support moderation by treatment setting, acculturation research calls for the study of conditional effects (i.e., socioecological factors) at different levels of cultural values (Castro et al., 2010).

A recent study conducted on a sample of Latino male OH residents found that, those with Latina/o cultural orientation and bicultural orientation and who endorse average to high levels of Familismo reported fewer years of substance abuse compared to those with U.S. mainstream cultural orientation and low Familismo (Lopez-Tamayo, Seda, & Jason, 2016). This finding underscores the importance of exploring acculturation processes in relation to substance abuse recovery (Bacio et al., 2013).

This result also brings into question whether current treatment available meets the needs of Latinas/os in recovery (Alvarez et al., 2007). A study conducted on a sample from the National Improvement Evaluation System found that matching services to needs was an effective strategy to enhance duration and post-treatment effectiveness for all groups, except for Latinas/os (Marsh, Cao, Guerrero, & Shin, 2009). Conversely, a study identified greater unemployment and housing instability as predictors of poor treatment completion among African Americans and Latinas/os (Saloner & LeCook, 2013). The findings suggest that Latina/o OH residents not only are getting their basic needs met (i.e., housing, employment), but they also are acculturating to the U.S. cultural practices. Taken together, participating recovery homes promote substance abuse recovery and the acculturation process among Latina/o residents.

It is also plausible that house processes promote abstinence self-efficacy among house residents, which, in turn, reduce substance abuse behavior. Recent studies on the same group of Latina/o OH residents have examined treatment differences and cultural values in relation to substance use recovery. A study that

compared Latina/o participants assigned to culturally-modified OHs and Traditional OHs found increases in employment income and decreased substance use in both settings, with greater income and reduced substance use among those assigned to a culturally-modified OH (Jason, DiGangi, Alvarez, Contreras, Lopez, Gallardo, & Flores, 2013). A further examination of the interaction between treatment setting and cultural values revealed that those with higher collectivism tended to stay longer in traditional OHs, while those assigned to a culturally-modified OH spend less time and had less relapse compared to those assigned to traditional OHs (Jason, Luna, Alvarez, & Stevens, 2016). The environmental and interpersonal contexts are essential in the development of prevention and treatment programs that are culturally-focused for Latinas/os in substance use recovery (Castro et al., 2010). Moreover, further investigation is needed to advance our knowledge about cultural values as it relates to complex issues associated with substance abuse (Castro et al., 2010).

Conclusions, Limitations, and Implications.

The aim of the present study was twofold: 1) examine a model of multidimensional acculturation that examined behavioral acculturation (i.e., Latina/o cultural practices and U.S. mainstream cultural practices) in relation to substance abuse at different values of attitudinal acculturation, and 2) explore the moderation effect of treatment environment (i.e., culturally-modified OH, Traditional OH) on acculturation dimensions (i.e., Latina/o cultural practices, U.S. mainstream cultural practices, attitudinal acculturation), acculturation process (i.e., house processes, house environment) and recovery of Latina/o OH

residents. Previous research on Latinas/os with SUDs have focused on lifetime use and prevalence of substance use (Alegria et al., 2007; Alvarez et al., 2007), length of stay in residential drug treatment (Amodeo, Chassler, Oettinger, Labiosa, & Lundgren, 2007; Saloner & Le Cook, 2013), and differences in nativity and acculturation in relation to substance use (Alegria et al., 2008; Ojeda, Patterson, & Strathdee, 2008). While the above studies were conducted on national datasets, this is the first study that had examined the conditional effect of behavioral acculturation on substance abuse at various levels of attitudinal acculturation using a sample of Latinas/os in recovery from SUDs,

Several unique contributions emerged from the present study. First, compared to U.S. mainland-born participants, increased endorsement of U.S. mainstream cultural practices lead to more days using alcohol in the past six months (baseline), particularly among those with high and very high affiliation to the U.S. mainstream culture. Conversely, compared to Latina/o immigrants, U.S. mainland-born Latinas/os who endorsed greater U.S. mainstream cultural practices used drug fewer days, but only those with very high affiliation of U.S. mainstream culture. These findings illustrate the mechanisms through which higher order values (i.e., attitudes) shaped cultural practices in relation to days participants used alcohol and drugs in the past six months at baseline. Moreover, the use of a dimensional approach allowed for a more accurate depiction of substance abuse behavior through the endorsement of cultural practices contingent on affiliation to the U.S. mainstream culture. Given the need for research on the adaptation of substance abuse prevention and treatment programs

(SAMHSA, 2014), these results demonstrate the contribution of acculturation dimensions in the development of substance abuse. Overall, acculturation dimensions and cultural values should be incorporated into current prevention intervention research that informs the development of culturally-grounded SAT and after care programs.

Second, this study demonstrated that Latina/o participants who remained longer at traditional OHs experienced and increased affiliation with the U.S. mainstream culture. Acculturation researchers suggest that the context of reception allows for the blendedness of cultural practices, therefore fostering biculturation (Benet-Martinez et al., 2006). To further move the field of acculturation, it is essential to examine the development of dual cultural identities and the interaction between them. More important, there is the need for theoretical frameworks that examine how cultural exposure (i.e., treatment environment) assists Latinas/os in recovery with shaping their cognitions, which, in turn, inform their engagement in cultural practices. Much more research is needed to understand how treatment environment contributes to the acculturation process.

Third, this study shed light in the immigrant paradox literature by identifying reductions in days Latina/o immigrants used drugs in the past six months among those endorsing moderate, high and very high Latina/o cultural practices. Notably, this result suggests that engagement in Latina/o cultural practices served as a protective factor against drug use among Latina/o immigrants in addiction recovery. In other words, greater endorsement of Latina/o cultural practices reduces drug use among Latina/o immigrants. Future research

should attempt to disentangle the cultural dissonance created by the context of reception in Latina/o immigrants by conducting longitudinal research that tracks changes in cultural values, attitudes, and behaviors over time.

Fourth, positive significant correlations between a valid and reliable measure of behavioral acculturation (i.e., non-Hispanic subscale of the Bidimensional Acculturation Scale) and treatment environment (i.e., the house processes and house environment subscales of the Oxford House Processes Questionnaire) demonstrated the need to explore the cultural context that inform the acculturation process of Latina/o OH residents. Fifth, the influence that treatment environment exerted on Latina/o participants was bidirectional in that more engagement with other OH residents (i.e., house environment) reduced Latina/o cultural practices and increased U.S. mainstream cultural practices among Latina/o participants assigned to a culturally modified OH. Sixth, Latina/o house participants with increased values of house processes showed a reduction in days using alcohol and drugs in the past six months at follow-up. Overall, these findings demonstrate the importance of including acculturation in the development of more culturally-relevant substance abuse prevention and treatment approaches for Latinas/os.

There were noteworthy limitations in the present study. Results from Hypotheses Ia and Ib should be interpreted in light of the following limitations. First, the cross-sectional nature of the analysis precludes us from establishing causal effects. Second, the lack of data on participants' socioeconomic status may mask the influence of socioeconomic factors in both, immigrant and U.S.

mainland-born participants. This is a significant limitation given that socioeconomic status influences the acculturation process for Latina/o immigrants through access to resources and social capital (Abraido-Lanza, Armbrister, Florez, & Aguirre, 2006). Third, the use of retrospective recall to identify days using alcohol and dug use in the past six months might be a limitation for two reasons: a) recall is subject to memory distortion; and b) participants may underreport substance use due to social desirability. Also, alcohol and drug use in the past six months shed light on the frequency, but not on the severity of SUDs reported by participants. Fourth, the limited number of women participating in the study (n = 18) did not allow for the examination of gender differences concerning the outcomes of interest.

Results from Hypothesis II and research questions should be interpreted with caution given the following limitations: a) participants could not be randomized to either a culturally modified OH or a traditional OH due to logistic constraints. Therefore, participants assigned to a traditional OH were either immigrants or U.S. mainland–born Latinas/os (information about assignment to either a traditional OH or to a culturally modified OH is available in the Procedures section under Methods); b) as noted above, changes in the frequency of days participants used alcohol and drugs in the past six months were reported, however data on severity of alcohol and drug use were not collected; c) most Latina/o immigrants who were assigned to a traditional OH either had a basic knowledge of the English language or were paired with a bilingual Latina/o OH resident to facilitate integration in house activities. It is plausible that Latina/o

immigrants who received additional peer support from a bilingual Latina/o resident had more resources that promoted change toward the U. S. mainstream culture. For example, in a prospective study exploring acculturation trajectories from childhood to adulthood, Castro and colleagues (2010) found that Latinas/os with more social capital and community resources showed greater lifetime assimilation change toward the U. S. mainstream culture; d) although the present analysis used two data points (e.g., baseline and six-month follow-up), the small sample size (n = 84) limited the inclusion of more variables in the model; and e) given the nature of this sample, generalization of findings may be limited to other Latinas/os who have completed SAT.

The current study has important implications for research on culturally grounded substance abuse prevention and treatment. First, there is a growing body of literature supporting the development and testing of culturally-appropriate models that examine the effects of acculturation on substance abuse (Castro & Alarcon, 2002). Moreover, results from the present study disaggregating acculturation domains and components related to substance abuse support the need for complex models. These types of study designs can provide valuable information regarding cultural practices and perceptions relative to substance abuse behavior among Latinas/os in recovery. Second, acculturation research is called to provide a more nuanced examination of the mechanisms, dynamics, and treatment conditions that either support or hinder the acculturation process of Latinas/os in relation to substance use behavior. Only by examining how acculturation occurs within and between the treatment settings researchers may

identify interactions among individuals' cultural practices, house processes, and social networks.

Acculturation research calls for research on changes in cultural values, perceptions and social practices relative to substance abuse behavior (Abraido-Lanza et al., 2006). The acculturation process is similar to the natural process of behavioral adaptation to fit in a recovery home. This process implies that acculturation is driven by a set of general laws that operate independently of contextual and individual factors (Chirkov, 2009). Although some acculturation theorists posit that the psychological processes implicated in the acculturation process are the same for all groups (Berry & Sam, 1997), the study of the inter and intra subjective meaning of cultural values and conventions is needed to shed light on the acculturation process (Benson, 2001). Thus, future research on Latinas/os in recovery should focus on the meaning and interpretations of cultural values (i.e., family, friends, food) and social practices (i.e., social gatherings) within the treatment environment.

Overall, besides examining changes in acculturation components, it is needed to conduct a cultural analysis of the social conventions adopted by Latinas/os in their home culture and the U.S. mainstream culture. Gaining a better understanding of the immigrants and U.S. mainland-born experiences within a particular environment and the dynamics of how they negotiate changes in cultural values and social norms would shed light on personal and community factors implicated in the acculturation process. By the same token, a consideration of the intersection of socioecological factors and cultural values is critical to

changing the current paradigm from linear models to models that are multidimensional (Abraido-Lanza et al., 2006). Overall, research employing multidimensional models of acculturation may inform the development of prevention and substance abuse treatment for Latinas/os in recovery.

As Latinas/os in recovery may endorse different acculturation levels, prevention interventions in the community should capitalize on the collectivistic nature of the Latina/o culture by promoting community involvement where participants develop self-confidence and self-efficacy (Bandura, 1986). The confidence that an individual has about his or her abilities to remain sober (specific self-efficacy) can be generalized to other settings, increasing self-agency through community participation. Emphasis should be placed on prevention programs building social and human capital (e.g., learning social conventions, strengthening social networks, building community support systems) that facilitate the process of acculturation, promoting healthy behaviors and reducing substance use behaviors. Recovery homes may be a viable option for Latinas/os in recovery in that fosters abstinence, social support, accountability, increased self-esteem and a sense of purpose (Alvarez, Jason, Davis, Olson, & Ferrari, 2009).

Findings from the present study suggest several clinical implications for practitioners to consider. First, assessment of cultural orientation and practices in Latina/os who are enrolled in SAT may assist practitioners in assigning individuals to SAT or recovery homes that share similar cultural perspectives (Burrow-Sanchez, Meyers, Corrales, & Ortiz-Jensen, 2015). By matching participants to treatment based on the degree of cultural relevance would

maximize cultural fit and treatment outcomes. Secondly, measuring the individual's acculturation level and substance use behavior pre and post treatment, and at multiple points over time would facilitate the evaluation of existing SAT programs. Data from multiple data points may inform the development of culturally-appropriate SAT programs for this population (Castro et al., 2010).

CHAPTER V

SUMMARY

The use of acculturation as a determining factor on the well-being of Latinas/os living in the United States is complex. The increasing number of Latinas/os with SUDs presents a unique opportunity to assess for treatment environment as it is linked to utilization and completion of SAT. Studies on treatment environment (Jacobson, 2004) help in understanding the impact of the neighborhood, poverty level, low educational attainment, and social cohesion relative to substance abuse behavior. Substance use recovery should consider the influence of acculturation norms, values, and beliefs of Latinas/os as these constructs are critical to tailor and develop culturally appropriate SAT. Furthermore, socioecological factors can affect the acculturation process of Latinas/os and, ultimately, impact substance abuse treatment utilization (Wallace et al., 2010).

The acculturation process varies between ethnic groups and within ethnic groups (Castro & Alarcon, 2002). Mounting evidence indicates that acculturation is associated with a broad range of behavioral and attitudinal variables that directly and indirectly impact the individual's well-being (Castro et al., 2010). The need to differentiate the multiple processes through which acculturation influence outcome behaviors, particularly substance abuse supports the use of comprehensive theoretical models (Bacio et al., 2013). Based on the ecological model of acculturation, this process occurs at both the societal level impacting

social structure (Chirkov, 2009) and the individual level (Berry, 2003; Castro et al., 2010).

The present study illustrates the impact of acculturation dimensions and attitudes relative to substance use behavior (Castro et al., 2010). With a growing population of Latinas/os that become the largest ethnic minority in 2042 (U. S. Census Bureau, 2014), there is an urgent need for culturally-inclusive prevention-intervention programs for Latina/o adults in recovery from substance use disorders. Emphasis should be placed on prevention programs building social and human capital (e.g., learning social conventions, strengthening social networks, building community support systems) that facilitate the process of acculturation, promoting healthy behaviors and reducing substance use behaviors.

References

Abraído-Lanza, A. F., Armbrister, A. N., Flórez, K. R., & Aguirre, A. N. (2006). Toward a theory-driven model of acculturation in public health research. *American journal of public health*, *96*(8), 1342-1346.

Akhtar, S., & Choi, L. W. (2004). When evening falls: The immigrant's encounter with middle and old age. *American Journal of Psychoanalysis, 64,* 183–191.

Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for 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.

Alegría, M., Page, J. B., Hansen, H., Cauce, A. M., Robles, R., Blanco, C., … Berry, P. (2006). Improving drug treatment services for Hispanics: Research gaps and scientific opportunities. *Drug and Alcohol Dependence*, *84*(SUPPL.), 76–84.

Alegria, M., Sribney, W., & Mulvaney-Day, N. E. (2007). Social cohesion, social support and health among Latinos in the United States. *Social Science and Medicine*, *64*(2), 477-495.

Alvarez, J., Jason, L. A., Olson, B. D., Ferrari, J., & Davis, M. I., (2007). Substance abuse prevalence and treatment among Latinos and Latinas. *Journal of Ethnicity in Substance Abuse*, 6(2), 115-141.

Alvarez, J., Olson, B.D., Jason, L. A., Davis, M. I., & Ferrari, J. R. (2004). Heterogeneity among Latinas and Latinos in substance abuse treatment:

Findings from a national database. *Journal of Substance Abuse Treatment, 16*, 277-284.

Amaro, H., Larson, M. J., Gampel, J., Richardson, E., Savage, A., & Wagler, D. (2005). Racial/ethnic differences in social vulnerability among women with co-occurring mental health and substance abuse disorders: Implications for treatment services. *Journal of Community Psychology, 33*, 495–511.

Arends-To´th, J., & van de Vijver, F. J. R. (2004). Domains and dimensions in acculturation: Implicit theories of Turkish–Dutch. *International Journal of Intercultural Relations, 28*(1), 19–35.

Arndt, S., Acion, L., & White, K. (2013). How the states stack up: Disparities in substance abuse outpatient treatment completion rates for minorities. *Drug and Alcohol Dependence, 132*(3), 547–554.

Arroyo, J. A., Miller, W. R., & Tonigan, J. S. (2003). The influence of Hispanic ethnicity on long-term outcome in three alcohol-treatment modalities. *Journal of Studies on Alcohol, 64*(1), 98-104.

Arroyo, J. A., Westerberg, V. S., & Tonigan, J. S. (1998). Comparison of treatment utilization and outcome for Hispanics and non-Hispanic whites. *Journal of Studies on Alcohol, 59*(3), 286-291.

Bachman, J.G., O'Malley, P.M., Schulenberg, J.E., Johnston, L.D., Bryant, A.L., & Merline, A.C. (2002). *The decline of substance use in young adulthood: Changes in social activities, roles, and beliefs.* Mahwah, NJ: Lawrence Erlbaum

Bandura, A. (1999). A sociocognitive analysis of substance abuse: An agentic perspective. *Psychological science*, *10*(3), 214-217.

Bhatia, S., & Ram, A. (2009). Theorizing identity in transnational and diaspora cultures: A critical approach to acculturation. *International Journal of Intercultural Relations, 33*(2), 140–149.

Benet-Martínez, V., & Haritatos, J. (2005). Bicultural identity integration (BII): Components and psychosocial antecedents. *Journal of personality*, *73*(4), 1015-1050.

Bernal, G., & Saenz-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology, 34,* 121-132.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*(6), 697-712.

Berry, J. W. (2009). A critique of critical acculturation. *International Journal of Intercultural Relations*, *33*(5), 361-371.

Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (Eds.). (2006). *Immigration youth in cultural transition: Acculturation, identity, and adaptation across national contexts.* Mahwah, NJ: Lawrence Erlbaum Associates.

Berry, J. W., & Sam, D. (1997). Acculturation and adaptation. In Berry, J. W., Seagull, M. H., & Kagitc ibasi, C. (Eds.), *Handbook of cross-cultural psychology: Social behavior and applications. Vol. 3* (pp. 291–326). Needham Heights, MA: Allyn & Bacon.

Boardman, J. D., Finch, B. K., Ellison, C. G., Williams, D. R., & Jackson, J. S. (2001). Neighborhood disadvantage, stress, and drug use among adults. *Journal of health and social behavior*, 151-165.

Brameld, T. (2007). *Social work with Latinos: a cultural assets paradigm*. New York, NY: Oxford University Press.

Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-40). Early data on a new scale. *Journal of interpersonal violence*, *4*(2), 151-163.

Bronfenbrenner, U. (1979). *The ecology of human development.* Cambridge, MA: Harvard University Press.

Brubaker, R. (2004). Rethinking classical theory: The sociological vision of Pierre Bourdieu. In D. L. Swartz & V. L. Zolberg (Eds.), *After Bourdieu: Influence, critique, elaboration* (pp. 25–64). Dordrecht, the Netherlands: Kluwer.

Burrow-Sánchez, J. J., Minami, T., Hops, H., & Burrow-Sánchez, J. J. (2015). Cultural Diversity and Ethnic Minority Psychology Cultural Accommodation of Group Substance Abuse Treatment for Latino Adolescents: Results of an RCT. *Cultural Diversity and Ethic Minority Psychology*. Advance online publication.

Butler, S. F., Redondo, J. P., Fernandez, K. C., & Villapiano, A. (2009). Validation of the Spanish Addiction Severity Index Multimedia Version (S-ASI-MV). *Drug and Alcohol Dependence*, *99*(1), 18-27.

Canino, G., Vega, W. A., Sribney, W. M., Warner, L. A., & Alegría, M. (2008). Social relationships, social assimilation, and substance use disorders among adult Latinos in the US. *Journal of drug issues*, *38*(1), 69-101.

Caetano, R., Ramisetty-Mikler, S., Wallisch, L. S., McGrath, C., & Spence, R. T. (2008). Acculturation, drinking, and alcohol abuse and dependence among Hispanics in the Texas–Mexico border. *Alcoholism: Clinical and Experimental Research*, *32*(2), 314-321.

Castro, F. G., & Alarcón, E. H. (2002). Integrating cultural variables into drug abuse prevention and treatment with racial/ethnic minorities. *Journal of Drug Issues*, *32*(3), 783-810.

Castro, F. G., Barrera, M., Pantin, H., Martinez, C., Felix-Ortiz, M., Rios, R., ... & Lopez, C. (2006). Substance abuse prevention intervention research with Hispanic populations. *Drug and Alcohol Dependence*, *84*, S29-S42.

Castro, F. G., Marsiglia, F. F., Kulis, S., & Kellison, J. G. (2010). Lifetime segmented assimilation trajectories and health outcomes in Latina/o and other community residents. *American Journal of Public Health*, *100*(4), 669-676.

Center for Substance Abuse Treatment (1999). Brief Interventions and Brief Therapies for Substance Abuse. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). (Treatment Improvement Protocol (TIP) Series, No. 34.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK64947/

Center for Substance Abuse Treatment (2014). *Improving Cultural Competence. Rockville, MD: Substance Abuse and Mental Health Services Administration.* (Treatment Improvement Protocol (TIP) Series, No. 59.) 1, Introduction to Cultural Competence. Retrieved from: http://www.ncbi.nlm.nih.gov/books/NBK248431/SAMHSA

Cervantes, R. C., Gilbert, M. J., Salgado de Snyder, N., & Padilla, A. M. (1991). Psychosocial and cognitive correlates of alcohol use in younger adult immigrants and U.S.-born Hispanics. *The International Journal of the Addictions, 25*, 687-708.

Chen, S. X., Benet-Martínez, V., & Harris Bond, M. (2008). Bicultural Identity, bilingualism, and psychological adjustment in multicultural societies: immigration-based and globalization-based acculturation. *Journal of personality*,*76*(4), 803-838.

Chirkov, V. (2009). Critical psychology of acculturation: What do we study and how do we study it, when we investigate acculturation? *International Journal of Intercultural Relations*, *33*(2), 94-105.

Clifford, P. R., & Longabaugh, R. (1991). Manual for the Administration of the Important People and Activities Instrument. (available from Richard Longabaugh, Brown University, Center for Alcohol and Addiction Studies, 800 Butler Drive, Providence, RI, 02906).

Coleman, J. S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94* (Suppl.), 95–120.

Contreras, R., Alvarez, J., DiGangi, J., Jason, L.A., Sklansky, L., Mileviciute, I., . . . Ponziano, F. (2012). No place like home: Examining a bilingual-bicultural, self-run substance abuse recovery home for Latinos. *Global Journal of Community Psychology Practice*, 3, 2-9.

Contreras, R., Gómez, D., López-Tamayo, R., Rodriguez, S., & Jason, L.A. (2016). Examination of the Living Environment of Oxford Houses with Latino Residents. *Substance Abuse and Aftercare.* Hauppauge, NY: Nova Science Publishers.

Corral, I., & Landrine, H. (2008). Acculturation and ethnic-minority health behavior: a test of the operant model. *Health Psychology*, *27*(6), 737.

Cuellar, I., Arnold, B., & Maldonado, R. (1995). Acculturation Rating Scale for Mexican Americans–II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17,* 275–304.

De La Rosa, M. R., Holleran, L. K., Rugh, D., & MacMaster, S. A. (2005). Substance abuse among US Latinos: A review of the literature. *Journal of Social Work Practice in the Addictions*, *5*(1-2), 1-20.

De La Rosa, M., Sanchez, M., Dillon, F. R., Ruffin, B. A., Blackson, T., & Schwartz, S. (2012). Alcohol use among Latinos: a comparison of pre-immigration, post-immigration, and US born Latinos. *Journal of Immigrant and Minority Health*, *14*(3), 371-378.

DiClemente, C. C., Doyle, S. R., & Donovan, D. (2009). Predicting treatment seekers' readiness to change their drinking behavior in the COMBINE Study. *Alcoholism: Clinical and Experimental Research*, *33*(5), 879-892.

Dominelli, L. (2002). *Anti-oppressive social work theory and practice.* New York: Palgrave MacMillan.

Domínguez, S., & Maya-Jariego, I. (2008). Acculturation of host individuals: Immigrants and personal networks. *American Journal of Community Psychology*, *42*(3-4), 309-327.

Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. *The American journal of psychiatry*, *165*(2), 179-187.

Eitle, T. M., Wahl, A. M. G., & Aranda, E. (2009). Immigrant generation, selective acculturation, and alcohol use among Latina/o adolescents. *Social science research*, *38*(3), 732-742.

Ennis, S. R., Ríos-Vargas, M., & Albert, N. G. (2011). The Hispanic population: 2010 (2010 Census Briefs C2010BR-04). Washington, DC: US Census Bureau. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf

Ellickson, P. L., & Morton, S. C. (1999). Identifying adolescents at risk for hard drug use: Racial/ethnic variations. *Journal of Adolescent Health*, *25*(6), 382-395.

Escobar, J. I. (1998). Immigration and mental health: Why are immigrants better off? *Archives of General Psychiatry*, *55*, 782.

Farley, T., Galves, A. L., Dickinson, L. M., & Perez, M. D. J. D. (2005). Stress, coping, and health: a comparison of Mexican immigrants, Mexican-Americans, and non-Hispanic whites. *Journal of immigrant health*, *7*(3), 213-220.

Felix-Ortiz, M., Newcomb, M.D. (1995). Cultural identity and drug use among Latino and Latina adolescents. In: Botvin, G.J., Schinke, S., Orlandi, M.A. (Eds.), *Drug Abuse Prevention with Multiethnic Youth* (pp. 147-165). Thousand Oaks, CA: Sage.

Ferrari, J., R., Groh, D. R., & Jason, L. A. (2009). The neighborhood environments of mutual-help recovery houses: Comparisons by perceived socio-economic status. *Journal of Groups in Addiction Recovery, 4*, 100-109.

Finch, B. K., & Vega, W. A. (2003). Acculturation stress, social support, and self-rated health among Latinos in California. *Journal of Immigrant Health, 5,* 109–117.

Finney, J. W., & Moos, R. H. (1991). The long-term course of treated alcoholism: I. Mortality, relapse and remission rates and comparisons with community controls. *Journal of studies on alcohol*, *52*(1), 44-54.

Fish, J. N., Maier, C. A., & Priest, J. B. (2015). Substance abuse treatment response in a Latino sample: The influence of family conflict. *Journal of substance abuse treatment*, *49*, 27-34.

Flannery, W. P., Reise, S. P., & Yu, J. (2001). An empirical comparison of acculturation models. *Personality and Social Psychology Bulletin*, *27*(8), 1035-1045.

Frazer, A. L., Rubens, S., Johnson-Motoyama, M., DiPierro, M., & Fite, P. J. Acculturation Dissonance, Acculturation Strategy, Depressive Symptoms, and Delinquency in Latina/o Adolescents. In *Child & Youth Care Forum* (pp. 1-15). Springer US.

Freeman, K. (2006). "If only my eyes were different": The loss of identity and underutilization of black children's educational potential- Rethinking social justice and assimilation. *Review of Education, 52*, 49-65.

Galaif, E. R., & Newcomb, M. D. (1999). Predictors of polydrug use among four ethnic groups: A 12-year longitudinal study. *Addictive Behaviors*, *24*(5), 607-631.

Gallo, L. C., Penedo, F. J., Espinosa de los Monteros, K., & Arguelles, W. (2009). Resiliency in the face of disadvantage: Do Hispanic cultural characteristics protect health outcomes? *Journal of Personality*, *77*(6), 1701-1746.

Ghorpade, J., Lackritz, J., & Singh, G. (2004). Psychological Acculturation of Ethnic Minorities Into White Anglo American Culture: Consequences and Predictors1. *Journal of Applied Social Psychology*, *34*(6), 1208-1228.

Gil. A., Wagner, E., & Vega, W. (2000). Acculturation, familism, and alcohol use among Latino adolescent males: Longitudinal relations. *Journal of Community Psychology*, *28*(4), 443-458.

Glanz, K., Rimer, B.K., & Lewis, F.M. (2002). *Health behavior and health education: theory, research and practice, 3rd edition*. New York, NY: Jossey-Bass.

Gordon, M. M. (1964). *Assimilation in American life: The role of race, religion and national origins*. New York, NY: Oxford University Press.

Grieco, E. M., Trevelyan, E., Larsen, L., Acosta, Y. D., Gambino, C., de la Cruz, G. P., ... & Walters, N. (2012). The size, place of birth, and geographic distribution of the foreign-born population in the United States: 1960 to 2010. *Population Division Working Paper, U. S. Census Bureau,* Paper No. *96*. Retrieved from https://www.census.gov/population/foreign/files/WorkingPaper96.pdf

Guerrero, E. G. (2013). Enhancing access and retention in substance abuse treatment: The role of Medicaid payment acceptance and cultural competence. *Drug and Alcohol Dependence*, *132*(3), 555–561.

Guerrero, E. G., Marsh, J. C., Duan, L., Oh, C., Perron, B., & Lee, B. (2013). Disparities in completion of substance abuse treatment between and within racial and ethnic groups. *Health services research*, *48*(4), 1450-1467.

Gustafson, P. (2001). Roots and Routes Exploring the Relationship between Place Attachment and Mobility. *Environment and behavior*, *33*(5), 667-686.

Haney, T. J. (2007). “Broken windows” and self-esteem: subjective understandings of neighborhood poverty and disorder. *Social Science Research*, *36*(3), 968-994.

Harvey, R., & Jason, L. A. (2011). Contrasting social climates of small peer-run versus a larger staff-run substance abuse recovery setting. *American Journal of Community Psychology*, *48*(3-4), 365-372.

Hirschi, T. (1969). *Causes of delinquency*. Berkeley, CA: University of California Press.

Hser, Y-I., Evans, E., Huang, D., & Anglin, D. M. (2004). Relationship between drug treatment services, retention, and outcomes. *Psychiatric Services*, *55*(7), 767–774.

Hubbard, R. L., Craddock, S. G., & Anderson, J. (2003). Overview of 5-year follow-up outcomes in the drug abuse treatment outcome studies (DATOS). *Journal of Substance Abuse Treatment*, *25*(3), 125-134.

Humphreys, K., Mankowski, E. S., Moos, R. H., & Finney, J. W. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, *21*(1), 54-60.

Huynh, Q. L., Nguyen, A. M. D., & Benet-Martínez, V. (2011). Bicultural identity integration. In *Handbook of identity theory and research* (pp. 827-842). New York, NY: Springer.

Jacobson, J. O. (2004). Place and Attrition from Substance Abuse Treatment. *Journal of Drug Issues*, *34*(1), 23–49.

Jacobson, J. O., Robinson, P. L., & Bluthenthal, R. N. (2007). Racial disparities in completion rates from publicly funded alcohol treatment: Economic resources explain more than demographics and addiction. *Health Services Research, 42*(2), 773-794.

Jason, L. A., Digangi, J. A., Alvarez, J., Contreras, R., Lopez-Tamayo, R., Gallardo, S., & Flores, S. (2013). Evaluating a bilingual voluntary community-based healthcare organization. *Journal of Ethnicity in Substance Abuse, 12*(4), 321-338.

Jason, L. A., & Ferrari, J. (2010). Oxford house recovery homes: Characteristics and effectiveness. *Psychological Services, 7*(2), 92-102.

Jason, L. A., Light, J. M., Stevens, E. B., & Beers, K. (2014). Dynamic Social Networks in Recovery Homes. *American Journal of Community Psychology*, *53*(0), 324–334.

Jason, L.A., Luna, R.D., Alvarez, J., & Stevens, E. (2016). Collectivism and individualism in Latino recovery homes. *Journal of Ethnicity in Substance Abuse.* 1-14.

Jason, L. A., Olson, B. D., & Foli, K. (2008). *Rescued Lives: The Oxford House approach to substance abuse.* New York, NY: Routledge.

Jason, L.A., Stevens, E., Ferrari, J.R., Thompson, E., & Legler, R. (2012). Social networks among residents in recovery homes. *Advances in Psychology Study, 1*, 4-12.

Joe, G. W., Simpson, D. D., & Broome, K. M. (1999). Retention and patient engagement models for different treatment modalities in DATOS. *Drug and Alcohol dependence*, *57*(2), 113-125.

Johnson, M. A. (2007). The social ecology of acculturation: Implications for child welfare services to children of immigrants. *Children and Youth Services Review*, *29*(11), 1426–1438.

Kelly, J. F., Stout, R. L., Magill, M., & Tonigan, J. S. (2011). The role of Alcoholics Anonymous in mobilizing adaptive social network changes: A prospective lagged mediational analysis. *Drug and Alcohol Dependence*, *114*(2), 119-126.

Koh, H. K., Graham, G., & Glied, S. A. (2011). Reducing racial and ethnic disparities: the action plan from the department of health and human services. *Health Affairs*, *30*(10), 1822-1829.

Laudet, A. B., Ph, D., Stanick, V., & Ph, D. (2010). Predictors of motivation for abstinence at the end of outpatient substance abuse treatment. *Journal of Substance Abuse Treatment*, *38*(4), 317–327.

Lara, M., Gamboa, C., Kahramanian, M. I., Morales, L. S., & Hayes Bautista, D. E. (2005). Acculturation and Latino health in the United States: a review of the literature and its sociopolitical context. *Annual Review of Public Health*, *26*, 367-397.

Latkin, C. A, Knowlton, A. R., Hoover, D., & Mandell, W. (1999). Drug network characteristics as a predictor of cessation of drug use among adult injection drug users: a prospective study. *American Journal of Drug and Alcohol Abuse, 25*, 463–73.

Laudet, A. B., & Humphreys, K. (2013). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services? *Journal of Substance Abuse Treatment*, *45*(1), 126-133.

Laudet, A. B., & Stanick, V. (2010). Predictors of motivation for abstinence at the end of outpatient substance abuse treatment. *Journal of substance abuse treatment*, *38*(4), 317-327.

Le, T. N., & Stockdale, G. (2008). Acculturative dissonance, ethnic identity, and youth violence. *Cultural diversity and ethnic minority psychology*, *14*(1), 1-19.

Lipsky, S. & Caetano, R. (2009). Epidemiology of substance abuse among Latinos. *Journal of Ethnicity in Substance Abuse*, *8*(3), 242-260.

Longabaugh, R., Wirtz, P. W., Beattie, M. C., Noel, N. & Stout, R. L. (1995). Matching treatment focus to patient social investment and support: 18-month follow-up results. *Journal of Consulting and Clinical Psychology*, *63*(2), 296-307.

Lopez-Tamayo, R., Alvarez, J., & Jason, L.A. (2016). Testing a Multidimensional Acculturation Model on Latinos who complete substance abuse treatment. *Journal of Drug Abuse, 2(2), 1-8.*

Lopez-Tamayo, R., DiGangi, J., Segovia, G., Leon, G., Alvarez, J., & Jason, L.A. (2016). Psychosocial factors associated with substance abuse on immigrant and U. S. born Latinos**.** *Journal of Addiction & Prevention, 4*(1), 1-10.

Lopez-Tamayo, R., Seda, A., & Jason, L.A. (2016). The role of familismo and acculturation as moderators of the association between family conflict and substance abuse on Latino adult males. *Public Health - Open Journal*. 48-56.

Luke, D. A. (2005). Getting the big picture in community science: Methods that capture context. *American Journal of Community Psychology*, *35*(3-4), 185–200.

Maldonado-Molina, M. M., Reingle, J. M., Jennings, W. G., & Prado, G. (2011). Drinking and driving among immigrant and US-born Hispanic young adults: Results from a longitudinal and nationally representative study. *Addictive behaviors*, *36*(4), 381-388.

Marin, G., & Gamba, R. J. (1996). A new measurement of acculturation for Hispanics: The bidimensional acculturation scale for Hispanics (BAS). *Hispanic Journal of Behavioral Sciences, 18(3),* 297-316.

Martinez, C. R. (2006). Effects of Differential Family Acculturation on Latino Adolescent Substance Use. *Family Relations*, *55*(3), 306-317.

McLellan, A. T., Urschel, H. C., & Blair, J. (1997). Addiction Severity Index, 5th Edition.

McQueen, A., Getz, J., & Bray, J. H. (2003). Acculturation, substance use, and deviant behavior: Examining separation and family conflict as mediators. *Child development*, *74*(6), 1737-1750.

McCarty, C. (2002). Structure in personal networks. *Journal of Social Structure*, *3*(1), 20. Retrieved from http://www.cmu.edu/joss/content/articles/volume3/McCarty.html

McCarty, C., & Wutich, A. (2005). Conceptual and empirical arguments for including or excluding ego from structural analyses of personal networks. *Connections*, *26*(2), 82-88.

McGoldrick, M., Pearce, J. K., & Giordano, J. (1983). *Ethnicity and family therapy*. New York, NY: The Guildford Press.

Mendoza, N. S., Conrow, L., Baldwin, A., & Booth, J. (2013). Using GIS to describe risk and neighborhood-level factors associated with substance abuse treatment outcomes. *Journal of Community Psychology*, *41*(7), 799-810.

Miller, H. V. (2011). Acculturation, Social Context, and Drug Use: Findings from a Sample of Hispanic Adolescents, *American Journal of Criminal Justice*, *36*(2), 93–105.

Miller, W. R. (1996). *Form 90: A structured assessment interview for drinking and related behaviors: Test manual*. US Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism.

Molina, K. M., Alegría, M., & Chen, C. N. (2012). Neighborhood context and substance use disorders: a comparative analysis of racial and ethnic groups in the United States. *Drug and alcohol dependence*, *125*, S35-S43.

Moos, R. H. (1973). Conceptualizations of human environments. *American psychologist*, *28*(8), 652-665.

Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders, *88*, 109–121.

Motel, S., & Patten, E. (2013). *Statistical portrait of the foreign-born population in the United States, 2011*. Washington, DC: Pew Research Center, 2013.

Ngo, V. H. (2008). A critical examination of acculturation theories. *Critical Social Work*, *9*(1), 1-6.

Ojeda, V. D., Patterson, T. L., & Strathdee, S. A. (2008). The influence of perceived risk to health and immigration-related characteristics on substance use among Latino and other immigrants. *American Journal of Public Health*, *98*(5), 862.

Oetting, E.R., Beauvais, F. (1987). Peer cluster theory: social characteristics and adolescent drug use: a path analysis. *Journal of Counseling Psychology*, *34*(2), 205–213.

Otiniano Verissimo, A. D., Gee, G. C., Ford, C. L., & Iguchi, M. Y. (2014). Racial discrimination, gender discrimination, and substance abuse among Latina/os nationwide. *Cultural Diversity and Ethnic Minority Psychology*, *20*(1), 43.

Oxford House Inc. (2008). *Oxford House Manual 2008.* Retrieved from http://www.oxfordhouse.org/userfiles/BasicOHManual2008a.pdf

Peña, J. B., Wyman, P. A., Brown, C. H., Matthieu, M. M., Olivares, T. E., Hartel, D., & Zayas, L. H. (2008). Immigration generation status and its association with suicide attempts, substance use, and depressive symptoms among Latino adolescents in the USA. *Prevention Science*, *9*(4), 299-310.

Perron, B. E., Mowbray, O. P., Glass, J. E. Delva, J., Vaughn, M. G., & Howard, M. O. (2009). Differences in service utilization and barriers among Blacks, Hispanics, and Whites with drug use disorders. *Substance Abuse Treatment, Prevention, and Policy*, 4(3)

Pew Research Center (2013). Second-Generation Americans, a portrait of the adult children of immigrants. Retrieved from http://www.pewsocialtrends.org/files/2013/02/FINAL_immigrant_generations_report_2-7-13.pdf

Phinney, J. (1990). Ethnic identity in adolescents and adults: A review of research. *Psychological Bulletin*, *108,* 499-514.

Pokhrel, P., Herzog, T. A., Sun, P., Rohrbach, L. A., & Sussman, S. (2013). Acculturation, social self-control, and substance use among Hispanic adolescents. *Psychology of Addictive Behaviors*, *27*(3), 674.

Portes, A., & Rumbaut, R. G. (Eds.). (2001). *Legacies: The story of the immigrant second generation*. Berkley, CA: University of California Press.

Portes, A. & Zhou, M. (1995). Divergent destinies: Immigration, poverty, and entrepreneurship in the United States. In K. McFate, R. Rawson & WJ Wilson (Eds.), *Poverty, inequality and future of social policy: Western states in the new world order* (pp.489-520). New York, NY: Russell Sage Foundation.

Prado, G., Szapocznik, J., Maldonado-Molina, M. M., Schwartz, S. J., & Pantin, H. (2008). Drug use/abuse prevalence, etiology, prevention, and treatment in Hispanic adolescents: A cultural perspective. *Journal of Drug Issues*, *38*(1), 5-36.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: applications to addictive behaviors. *American psychologist*, *47*(9), 1102-1114.

Redfield, R., Linton, R., & Herskovits, M. (1936). Memorandum on the study of acculturation. *American Anthropologist*, *38*(1), 149–152.

Robles, R. R., Matos, T. D., Colón, H. M., Deren, S., Reyes, J. C., Andía, J., ... & Sahai, H. (2003). Determinants of health care use among Puerto Rican drug users in Puerto Rico and New York City. *Clinical Infectious Diseases*, *37*(Supplement 5), S392-S403.

Rohmann, A., Piontkowski, U., & van Randenborgh, A. (2008). When attitudes do not fit: Discordance of acculturation attitudes as an ante- cedent of intergroup threat. *Personality and Social Psychology Bulletin, 34*, 337–352.

Rudmin, F. W. (2003). Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. *Review of General Psychology, 7*(1), 3–37.

Rumbaut, R. G. (2005). Children of immigrants and their achievement: the roles of family, acculturation, social class, gender, ethnicity, and school context. *Addressing the achievement gap: Theory informing practice*, 23-59.

Rumbaut, R. G. (2008). Reaping what you sow: Immigration, youth, and reactive ethnicity. *Applied Development Science, 12*(2), 108-111.

Saloner, B., & Lê Cook, B. (2013). Blacks and Hispanics are less likely than whites to complete addiction treatment, largely due to socioeconomic factors. *Health Affairs, 32*(1), 135-145.

Sahker, E., Toussaint, M. N., Ramirez, M., Ali, S. R., & Arndt, S. (2015). Addictive Behaviors Evaluating racial disparity in referral source and successful completion of substance abuse treatment. *Addictive Behaviors, 48*, 25-29.

Salabarria-Pena, Y., Trout, P. T., Gill, J. K., Morisky, D. E., Muralles, A. A., & Ebin, V. J. (2001). Effects of acculturation and psychosocial factors in Latino adolescents' TB-related behaviors. *Ethnicity and Disease, 11*(4), 661–675.

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science, 277*(5328), 918-924.

Schonpflug, U. (1997). Acculturation: Adaptation or development. Applied Psychology: An *International Review*, *46*(2), 53–55.

Schwandt, T. (2007). *The Sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage.

Schwartz, S. J., Pantin, H., Sullivan, S., Prado, G., & Szapocznik, J. (2006). Nativity and years in the receiving culture as markers of acculturation in ethnic enclaves. *Journal of Cross-Cultural Psychology, 37*, 345–353.

Schwartz, S. J., Unger, J. B., Zamboanga, B. L., & Szapocznik, J. (2010). Rethinking the concept of acculturation: implications for theory and research. *American Psychologist*, *65*(4), 237.

Schwartz, S. J., Unger, J. B., Des Rosiers, S. E., Lorenzo-Blanco, E. I., Zamboanga, B. L., Huang, S., ... & Szapocznik, J. (2014). Domains of acculturation and their effects on substance use and sexual behavior in recent Hispanic immigrant adolescents. *Prevention Science*, *15*(3), 385-396.

Schwartz, S. J., Weisskirch, R. S., Zamboanga, B. L., Castillo, L. G., Ham, L. S., Huynh, Q. L., ... & Davis, M. J. (2011). Dimensions of acculturation: associations with health risk behaviors among college students from immigrant families. *Journal of counseling psychology*, *58*(1), 1-15.

Schwartz, S. J., & Zamboanga, B. L. (2008). Testing Berry's model of acculturation: A confirmatory latent class approach. *Cultural Diversity and Ethnic Minority Psychology*, *14*, 275–285

Schwartz, S., Zamboanga, B., & Jarvis, L. H. (2007). Ethnic identity and acculturation in Hispanic early adolescents: Mediated relationships to academic grades, prosocial behavior, and externalizing symptoms. *Cultural Diversity and Ethnic Minority Psychology, 13,* 364–373.

Schwartz, S. J., Zamboanga, B. L., Tomaso, C. C., Kondo, K. K., Unger, J. B., Weisskirch, R. S., ... & Brittian, A. S. (2014). Association of acculturation with drinking games among Hispanic college students. *The American journal of drug and alcohol abuse*, *40*(5), 359-366.

Simpson, D. D., Joe, G. W., Broome, K. M., Hiller, M. L., Knight, K., & Rowan-Szal, G. A. (1997). Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, *11*(4), 279.

Sloboda, Z., Glantz, M. D., & Tarter, R. E. (2012). Revisiting the concepts of risk and protective factors for understanding the etiology and development of substance use and substance use disorders: Implications for prevention. *Substance Use & Misuse*, *47*(8-9), 944-962.

Stahler, G. J., Mazzella, S., Mennis, J., Chakravorty, S., Rengert, G., & Spiga, R. (2007). The effect of individual, program, and neighborhood variables on continuity of treatment among dually diagnosed individuals. *Drug and alcohol dependence*, *87*(1), 54-62.

Stephenson, M. (2000). Development and validation of the Stephenson Multigroup Acculturation Scale (SMAS). *Psychological Assessment, 12*(1), 77–88.

Stevens, E., Jason, L.A., Ram, D., & Light, J. (2015). Investigating social support and network relationships in substance use disorder recovery. *Substance Abuse. 36,* 396-399.

Suarez-Orozco, C., & Suarez-Orozco, M. M., & Todorova, I. (2008). *Learning a new land: Immigrant students in American society.* Cambridge, MA: Harvard University Press.

Substance Abuse and Mental Health Services Administration (2012). *Results from the 2011 National Survey on Drug Use and Health: Mental health findings.* MSDUH Series H-45, HHS Publication N. (SMA) 12-4725. Rockville, MD: SAMHSA. Retrieved from www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.htm

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Szal, G. A. (1997). Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 279-293.

Szapocznik, J., Kurtines, W., 1980. Acculturation, biculturalism and adjustment among Cuban Americans. In: Padilla, A.M. (Ed.), *Psychological Dimensions on the Acculturation Process: Theory, Models and Some New Findings* (pp. 139–159). Boulder, CO: Westview Press.

Szapocznik, J., Lopez, B., Prado, G., Schwartz, S. J., & Pantin, H. (2006). Outpatient drug abuse treatment for Hispanic adolescents. *Drug and Alcohol Dependence*, *84*, S54-S63.

Szapocznik, J., Prado, G., Burlew, K., Williams, R., & Santiesteban, D. (2007). Drug abuse in African American and Hispanic adolescents: Culture, development and behavior. *Annual Review of Clinical Psychology, 3,* 77-105.

Tardif-Williams, C. Y., & Fisher, L. (2009). Clarifying the link between acculturation experiences and parent–child relationships among families in cultural transition: The promise of contemporary critiques of acculturation psychology. *International Journal of Intercultural Relations, 33*(2), 150-161.

Tonigan, J. S. (2003). Project match treatment participation and outcome by self-reported ethnicity. *Alcoholism: Clinical & Experimental Research, 27,* 1340–1344.

Triandis, H. C. (1993). Comment on Misra and Gergen's: Place of culture in international science. *International Journal of Psychology, 28*(2), 249-250.

Triandis, H. C. (1997). Where is culture in the acculturation model. *Applied Psychology: An International Review, 46*(2), 55-58.

Tropp, L. R., Erkut, S., Coll, C. G., Alarcon, O., & García, H. A. V. (1999). Psychological acculturation: Development of a new measure for Puerto Ricans on the US mainland. *Educational and Psychological Measurement, 59*(2), 351-367.

Tseng, V. (2004). Family interdependence and academic adjustment in college youth from immigrant and U. S.-born families. *Child Development, 75*, 966–983.

Turner, R. J., Lloyd, D. A., & Taylor, J. (2006). Stress burden, drug dependence and the nativity paradox among U.S. Hispanics. *Drug and Alcohol Dependence, 83*, 79-89.

Ulrich, R. S., Simons, R. F., Losito, B. D., Fiorito, E., Miles, M. A. & Zelson, M. (1991). Stress recovery during exposure to natural and urban environments. *Journal of Environmental Psychology, 11*(3), 201-230.

Unger, J. B., Ritt-Olson, A., Wagner, K. D., Soto, D., & Baezconde- Garbanati, L. (2007). A comparison of acculturation measures among Hispanic/Latino adolescents. *Journal of Youth and Adolescence, 36*(4), 555–565.

Updegraff, K. A., & Umaña-Taylor, A. J. (2010). Structure and process in Mexican-origin families and their implications for youth development. *Growing up Hispanic: Health and Development of Children of Immigrants*, 97-143.

U.S. Census Bureau. (2012). *Projections show a slower growing, older, more diverse nation a half century from now*. Retrieved from https://www.census.gov/ newsroom/releases/archives/population/ cb12-243.html

US Department of Health and Human Services. (2011). Results from the 2010 National Survey on Drug Use and Health: Summary of national findings. *Substance Abuse and Mental Health Services Administration: Rockville, MD, USA*.

Valente, T. W., Chou, C. P., & Penz, M. A. (2007). Community coalitions as a system: effects of network change on adoption of evidence-based substance abuse prevention. *American Journal of Public Health, 97*(5), 880-886.

Vega, W. A., Canino, G., Cao, Z., & Alegria, M. (2009). Prevalence and correlates of dual diagnoses in U.S. Latinos. *Drug and Alcohol Dependence, 100*(1-2), 32–38.

Vega, W. A., & Gil, A. G. (1998). A model for explaining drug use behavior among Hispanic adolescents. *Drugs & Society*, *14*(1-2), 57-74.

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of general psychiatry*, *55*(9), 771-778.

Vega, W. A., Kolody, B., Valle, R., & Weir, J. (1991). Social networks, social support, and their relationships to depression among immigrant Mexican women. *Human Organization, 50*(2), 154-162.

Vega, W. A., Rodriguez, M. A., & Gruskin, E. (2009). Health disparities in the Latino population. *Epidemiologic reviews*, *31*(1), 99-112.

Volkow, N. D. (2011). *Principles of Drug Addiction Treatment: A Research-Based Guide*. Retrieved from https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podat_1.pdf

Wakefield, S. E., & Poland, B. (2005). Family, friend or foe? Critical reflections on the relevance and role of social capital in health promotion and community development. *Social Science & Medicine*, *60*(12), 2819-2832.

Walton, M. A., Blow, F. C., Bingham, C. R., & Chermack, S. T. (2003). Individual and social/environmental predictors of alcohol and drug use 2 years following substance abuse treatment. *Addictive behaviors*, *28*(4), 627-642.

Wandersman, A., & Nation, M. (1998). Urban neighborhoods and mental health: psychological contributions to understanding toxicity, resilience, and interventions. *American Psychologist, 53*, 648-649.

Warner, L. A., Valdez, A., Vega, W. A., de la Rosa, M., Turner, R. J., & Canino, G. (2006). Hispanic drug abuse in an evolving cultural context: An agenda for research. *Drug and Alcohol Dependence, 84*, S8-S16.

Wells, K., Klap, R., Koike, A., & Sherbourne, A. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse and mental health care. *American Journal of Psychiatry, 158*, 2027–2032

Wiatrowski, M. D., Griswold, D. B., & Roberts, M. K. (1981). Social control theory and delinquency. *American Sociological Review*, 46, 525-541.

Williams, C. T., & Latkin, C. A. (2007). Neighborhood socioeconomic status, personal network attributes, and use of heroin and cocaine. *American Journal of Preventive Medicine, 32*(6), S203-S210.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32*, 20–47.

Wasserman, D. A., Stewart, A. L., & Delucchi, K. L. (2001). Social support and abstinence from opiates and cocaine during opioid maintenance treatment. *Drug and Alcohol Dependence, 65*(1), 65-75.

Yan, J. C., Huan, D., & Hser, Y. (2006). Long-term morbidity and mortality among a simple of cocaine-dependent Black and White veterans. *Journal of Urban Health, 83*, 926–940.

Yoo, H. C., Gee, G. C., & Takeuchi, D. (2009). Discrimination and health among Asian American immigrants: Disentangling racial from language discrimination. *Social Science and Medicine, 68*(4), 726–732.

Zamboanga, B. L., Raffaelli, M., & Horton, N. J. (2006). Acculturation status and heavy alcohol use among Mexican American college stu- dents: An investigation of the moderating role of gender. *Addictive Behaviors, 31,* 2188–2198.

Zane, N., & Mak, W. (2003). Major approaches to the measurement of acculturation among ethnic minority populations: A content analysis and an alternative empirical strategy. In K. M. Chun, P. B. Organista, & G. Mar´ın (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 39 – 60). Washington, DC: American Psychological Association.

Zemore, S. E., Mulia, N., Ye, Y., Borges, G., & Greenfield, T. K. (2009). Gender, acculturation, and other barriers to alcohol treatment utilization among Latinos in three national alcohol surveys. *Journal of Substance Abuse Treatment, 36(*4), 446–456.

Zhou, M. (1997). Segmented assimilation: Issues, controversies, and recent research on the new second generation. *International migration review,* 975-1008.

Appendix A

Consent Form
(English and Spanish Version)

CONSENT TO PARTICIPATE IN RESEARCH

"Evaluating a Bilingual Voluntary Community-Based Healthcare Organization"

What is the purpose of this research?

We are asking you to be in a research study because we are trying to learn more about what kind of post-treatment program services work best for Latina/os/Latinas with drug or alcohol abuse problems. You are invited to participate in this study because you are a Latina/o/Latina who has just completed a treatment program. This study is being conducted by Leonard Jason at DePaul University.

How much time will this take?

The study will take 2-3 hours of your time. There will be a total of two interviews over a six-month period, at baseline and at month 6. Each interview will take 60 to 150 minutes to complete. The first interview will take place before you leave your treatment program. The other will take place either at your home or at a private office at DePaul University. In the event that we receive additional funding to continue the study, we may ask you if you would be willing to participate in another 60-150 minute interview at the 12-month time point.

What will I be asked to do if I agree to participate in this study?

You will be asked to do the following things:

- Complete interviews at the beginning, month 6 and possibly month 12 time points.
- Provide us with a list of important people in your life. If we are unable to locate you at any time during the study, we will call these people to give us information that will help us find you (or at least notify you that the interview date is near). If we contact these people, we will only tell them that we calling from DePaul University.
- We will ask your permission to contact the Oxford House officials, at any time during the study, if you for any reason leave the Oxford House during the research. We will ask them the reason why you left the Oxford House.
- We will ask you to sign a release of information form that will allow us to contact the Oxford House Official (as indicated above), as well as people on your important people list, the other people listed on the tracking form completed by you, and other agencies like Medical Centers, Treatment Centers, Correctional

Facilities, or the Department of Motor Vehicles, if at any time during the study we can not contact you.

- Allow us to inspect **criminal justice databases** regularly to assess whether you have engaged in any criminal activities. Your social security number will be used in an effort to determine if you have engaged in any criminal activities while you are in the study.
- In addition to calling your "important people" and utilizing these databases, if we are unable to locate you we may send two "trackers" to visit your last known address or your important people's addresses in an additional effort to locate you for your interviews. These visits will only occur during the daytime or early evening hours as a last resort to try and locate you for your interview. They will simply refer to themselves as from "DePaul University" and will ask if your current location is known. They may leave a business card for you at your last known address, for your important people, or for neighbors near your last known address. These business cards will contain the same generic information and a phone number for Richard Contreras at DePaul University, or the name of the tracker.

At the **initial interview,** a member of our research team will ask you a series of questions. Some questions focus on your past and current life, others on your opinions, and still others on your feelings and thoughts. The interviewers will request some personal and sensitive information. For example, questions will be asked about your drug and alcohol use, in addition to past and present criminal behavior and other issues such as depression, Post Traumatic Stress Disorder (PTSD), and trauma. PTSD is a condition that can occur after people experience really difficult, scary, or traumatic events. We are interested in talking to you about those events and learning how you coped with those experiences. You are not required to answer any question on any of the surveys if you do not want to. All information you give us will be kept confidential.

After you complete the first interview, you will be assigned randomly (by chance, like a flip of a coin) to *a* ***Culturally-Modified Oxford House,*** or a ***Traditional Oxford House.*** *Oxford House* is a type of recovery home run by the residents who help each other to remain sober.

- In the *Culturally-Modified Oxford House* residents will speak both English and Spanish and most people will be Hispanic/Latina/o. *Traditional Oxford Houses* will have at most 2 individuals in the House who are Hispanic/Latina/o. English will be the primary language used in these houses. If you are more comfortable speaking Spanish, there will be one other Spanish speaking person in the house who will be able to translate for you.
- In order to get placed in a local Illinois Oxford House, you will need to apply for entrance. Members of the House then vote on whether to accept you after meeting and talking to you. There is no guarantee that you will be accepted as a resident within an *Oxford House*, but based upon our experience there is a very good chance you will be accepted. If you are not accepted into an Oxford House, you will still be allowed to participate in the follow-up interview(s).
- To live in an *Oxford House* you must pay rent (about $100 a week), help with house chores, and abstain from using alcohol and other drugs. While you live in

Oxford House you may receive outpatient substance abuse treatment and you will be encouraged to attend 12-step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

Two months after the first interview, and your assignment to one of the two types of Oxford Houses listed above, we will phone you to be sure we have the correct phone number and address to contact you for the month-6 interview.

Just prior to the month-6 time point we will call you to ask you when would be a good time to have the interview. You may complete this interview in person at your home or at DePaul University, or on the telephone, whichever is easier for you. If additional funding is received to continue the study, you may be asked if you are willing to participate in an additional interview at the 12-month time point. We will ask for your verbal consent to participate in the third interview. Almost all of the interviews will involve questions that we will ask verbally and then we will write down your answers. At the first interview, one questionnaire will be answered using a computer. If you need assistance using the computer, we will help you.

What are the risks involved in participating in this study?

The research involves the discussion of potentially sensitive issues with interviewers and may result in your being uncomfortable or upset when you are asked to recall or talk about your past or present substance abuse or criminal behavior. Should the interviews cause you to be very emotionally upset, the DePaul research staff will help you with making arrangements for counseling and/or provide a list of local emergency rooms, community hospitals, and mental health clinics serving the Northern Illinois region. If you need help, we will help with the referral process.

Another risk is that someone could find out something that you said if information from your interviews were accidentally or mistakenly released. However, this has never happened before on any of our research projects, and we will take every step to ensure that your data is protected at all times.

If at any time we feel that there is a child in danger of abuse or neglect or that you may hurt yourself or others, we must report that to the proper authorities.

What are the benefits of my participation in the study?

You may not personally benefit from being in this study. We hope that the information we get from the study will lead to improvements in future programs for other people in recovery.

Will I receive any kind of payment for being in this study?

You will receive a $30.00 cash payment for answering the interview questions at each interview time point, for a total of $60.00. If additional funding is granted for us to continue the study and you are willing to participate in a third interview at the month 12 time point, you could earn an additional $30.00 payment, for a total of $90.00.

Can I decide not to participate?

Yes, you can choose not to participate. Even if you agree to be in the study now, you can change your mind later and leave the study. There will be no negative consequences if you decide not to participate or change your mind later. ***If you decide not to participate in this study, you will still be referred to any treatment program available to you, including Oxford House***. If you change your mind later, it will not affect your placement in the Oxford House.

How will the confidentiality of the research records be protected?

The records of this study will be kept confidential. We will not write your name on research records, but instead will write only an ID number. Only the research team will know what your ID number is, so that even if someone were to see the research records, they would not know the information is about you.

In any report we might publish or whenever we share our data from the study with anyone outside of the research team, we will not include any information that will identify you by name or other clear identifiers. Furthermore, no information that arises as part of the study will be given to the parole/probation officer or anyone else.

Finally, to help us protect your privacy, we have also have obtained a Certificate of Confidentiality from the National Institutes of Health. With this Certificate, we cannot be forced to disclose information that may identify you, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. The researchers will use the Certificate to resist any demands for information that would identify you.

The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of federally-funded projects.

You should understand that a Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information. The Certificate of Confidentiality does not prevent us from disclosing voluntarily, without your consent, information that would identify you as a participant in the research project under the following circumstances: child abuse and neglect or intent to hurt yourself or others.

Some people might review our records in order to make sure we are doing what we are supposed to. For example, the DePaul University Institutional Review Board or the funding agency for the research (the National Institute on Alcohol Abuse and Alcoholism) may review your information. If they look at our records, they will keep your information confidential.

Who can I contact for more information?

DePaul researcher Dr. Richard Contreras may be reached at (773) 325-4962, or by e-mail at rcontreras@depaul.edu who wmailto:ill be available to answer any future questions that may arise. If you have questions about your rights as a participant, you may contact Susan Loess-Perez, DePaul University's Director of Research Protections at 312-362-7593 or by email at sloesspe@depaul.edu.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have all my questions answered. (Check one:)

☐ I consent to be in this study.

☐ I **DO NOT** consent to be in this study.

Signature:_____Date: _____

Printed name: _____

Interviewer/Recruiter's responsibilities (for interviewer/recruiter to fill out):

The project has been fully explained to _____ (participant) including the nature and purpose of the above-described research procedures and the risks and benefits involved in its performance. As the recruiter/interviewer, I have asked questions about the participant's understanding of the consent form, and I have answered any questions the participant has had about the study. As the researcher, I will answer all future questions to the best of my ability. I will inform the participant of any changes in the procedures or the risks and benefits should any should occur during or after the course of the study. A copy of the consent form has been provided to the participant.

Signature of Person Obtaining Consent: _____Date:_____

Release Form- Most Important Person

As part of this study, the DePaul research team will need to contact my "most important person." This is a person who is close to me and may be able to provide the research team with contact information for me, if they have trouble contacting me for the follow-up interviews.

Therefore I, the participant, _____, give permission for DePaul University to contact:

Name: _____

Relationship: _____

Cell Phone Number: _____

Home Phone Number: _____

Mailing Address: _____

Name: _____

Relationship: _____

Cell Phone Number: _____

Home Phone Number: _____

Mailing Address: _____

Name: _____

Relationship: _____

Cell Phone Number: _____

Home Phone Number: _____

Mailing Address: _____

Name: _____

Relationship: _____

Cell Phone Number: _____

Home Phone Number: _____

Mailing Address: _____

Name: _____

Relationship: _____

Cell Phone Number: _____

Home Phone Number: _____

Mailing Address: _____

Name: _____

Relationship: _____

Cell Phone Number: _____

Home Phone Number: _____

Mailing Address: _____

_____

(As indicated on the tracking form)

The researchers will be contacting this person (via telephone, or by last resort, in person) at month 6, and possibly at month 12, if the research team has trouble finding me. I may withdraw my consent to participate in this study, including my permission to contact this person, at any time. Please talk to the person listed above so that they will know about their role in the study and that we will be calling them to ask questions about contacting you, if needed.

Participant's Signature: _____ Date_____

Witness' Signature: _____ Date_____

Release Form for Tracking Information

As part of this study, the DePaul research team will need to locate me for my follow-up interview(s). I have the opportunity to drop out of the study at any time by notifying the DePaul team [Richard Contreras]. However, while I am part of the study, the DePaul team will contact the Oxford House president and other people I have listed as "important people" in my life, if the research team cannot find or locate me. If the DePaul team has trouble locating me, the researchers will also attempt to get this information from various institutions that may have my relevant contact information (for example, treatment centers or correctional facilities). During the period of the study, if I leave the Oxford House the DePaul team will also contact the Oxford House President or other officers to determine the reasons for why I left this setting.

Therefore, I, the participant, _____, give the DePaul team permission to call any of the people listed on the Tracking Form or on the important people list, and gain access to my information form institutions, facilities, or databases that may have information that can help locate me such as Medical Centers, Treatment Centers, Correctional Facilities, Department of Motor Vehicles etc. I give permission to the DePaul team to contact the Oxford team to contact the Oxford House President or other officers to determine the reasons why I left this setting.

Permission to contact these people and institutions are granted:

Participant's Signature: _____ Date:_____

Witness' Signature: _____ Date:_____

CONSENTIMIENTO PARA PARTICIPAR EN LA INVESTIGACIÓN

"Evaluando una organización comunitaria voluntaria bilingüe para el cuidado de la salud"

¿Cuál es el propósito de esta investigación?

Estamos pidiendo que usted participe en esta investigación porque estamos tratando de aprender más sobre que tipos de programas funcionan mejor para los Hispanos/Latina/os(as) después de un tratamiento de abuso de drogas o alcohol. Usted ha sido invitado/a para participar en este estudio porque usted es un/una Latina/o/ Latina que acaba de terminar un programa de tratamiento. Este estudio se está llevando a cabo bajo la dirección de Leonard Jason de la Universidad de DePaul.

¿Cuánto tiempo tomará?

El estudio tomará 2-3 horas de su tiempo. Habrá un total de dos entrevistas en un periodo de seis meses. La primera entrevista será antes que termine su tratamiento y la segunda será seis meses después. Cada entrevista tomará de 60 a 150 minutos para completar. La primera entrevista ocurrirá antes que se vaya del programa de tratamiento. La otra ocurrirá en su hogar o en una oficina privada en la Universidad de DePaul. En caso de que recibamos el financiamiento adicional para continuar el estudio, podríamos preguntarle si usted estaría dispuesto a participar en otra entrevista de 60 a 150 minutos 12 meses después de la primera entrevista.

¿Qué me pedirán hacer si acepto participar en este estudio?

A usted le pedirán hacer las siguientes cosas:

- Terminar la primera entrevista (antes de salir del programa de tratamiento) y la segunda entrevista (seis meses) y posiblemente otra entrevista después de un año (mes12).
- Hacer una lista de personas importantes en su vida. Si no podemos localizarlo/a en cualquier momento durante el estudio, llamaremos a estas personas para que nos den información que nos ayude a localizarlo/a (o por lo menos notificarle que la fecha de la entrevista ya está cerca). Si contactamos a estas personas, solamente les diremos que estamos llamando de la Universidad de DePaul.
- Pediremos su permiso para contactar a los oficiales de "Oxford House," en cualquier momento durante el estudio. Si por alguna razón usted se va de "Oxford House" durante el estudio, les preguntaremos la razón por la cual usted salió de "Oxford House."
- Le pediremos que firme un documento de seguimiento de información que nos permitirá estar en contacto con los Oficiales de "Oxford House" (indicado arriba), así como con las personas importantes de su lista, las otras personas en el registro de seguimiento que fue completada por usted, y otras agencias como centros médicos,

centros de tratamiento, facilidades correccionales, o el departamento de vehículos, si en cualquier momento durante el estudio no podemos contactarlo/a.

- Pediremos su permiso para investigar un base de datos **(databases)** criminales regularmente para determinar si usted ha estado envuelto en cualquier actividad criminal. Su número de Seguro Social será utilizado en un esfuerzo para determinar si usted se ha involucrado en actividades criminales mientras que usted participa en el estudio.
- Además de llamar a sus "personas importantes" y utilizar las bases de datos (databases), si no podemos localizarlo/a vamos a enviar a dos personas para buscarlo/a. Estas personas van a visitar su última dirección conocida o las direcciones de sus "personas importantes" en un esfuerzo adicional para localizarlo/a para las entrevistas. Estas visitas sólo ocurrirán durante el día o en la tarde como un último recurso para tratar de localizarlo/a. Nos vamos a identificar solo como personas de la "Universidad de DePaul" y les preguntaremos a sus "personas importantes" o vecinos por su última dirección conocida. Tal vez, dejemos una tarjeta general con sus vecinos. Estas tarjetas contendrán información muy general y un número de teléfono con el nombre de Richard Contreras de la Universidad de DePaul o el nombre de las personas que lo/a están buscando.

En la entrevista inicial**,** un miembro de nuestro equipo de investigación le hará una serie de preguntas. Algunas preguntas se enfocaran en su vida pasada y actual, otras en sus opiniones, y aún otras en sus sentimientos y pensamientos. Los entrevistadores solicitarán información personal y delicada. Por ejemplo, se harán preguntas acerca de su uso de drogas y alcohol, además de su comportamiento criminal pasado y actual y de otros temas como depresión, Trastorno de Estrés Postraumático (TEP) y trauma. TEP es una condición que puede ocurrir después de una experiencia realmente difícil, temeroso, u traumáticos. Estamos interesados en hablar con usted sobre estos eventos y aprender cómo pudo enfrentarse con estas experiencias. Usted no está obligado a contestar cualquier pregunta en las encuestas si usted no quiere. Toda la información que usted nos de será mantenida confidencial.

Después de que usted termine la primera entrevista, le asignarán aleatoriamente (por casualidad, como un tirón de una moneda) a una ***"Oxford House" Modificada*** o a una ***"Oxford House" Tradicional. "****Oxford House*" es una casa de recuperación operada por los residentes quienes se ayudan a mantenerse sobrios.

- En la *"Oxford House" Modificada* los residentes hablarán inglés y español y la mayoría de la gente será Hispána/Latina. *"Oxford House" Tradicionales* tendrán al menos 2 individuos en la casa que son Hispanos/Latina/os. El inglés será la lengua primaria usada en estas casas. Si usted se siente más gusto hablando español, habrá una persona que habla español la cual le ayudara a traducir cuando lo necesite.
- Para ser colocado/a en una "Oxford House" local, usted necesitará aplicar para la entrada. Entonces los miembros de la casa votan para ver si lo/la aceptan después de conocerlo/a. No hay garantía que le aceptarán dentro de la casa como residente pero por nuestra experiencia hay una buena probabilidad que lo/la aceptarán. Si no lo/la aceptan en la casa, todavía será permitido/a participar en las entrevistas.
- Para vivir en una "Oxford House" usted tiene que pagar para aguilar un cuarto (cerca de $100 por semana), ayudar con los deberes de casa, y abstenerse de usar alcohol y otras drogas. Mientras que usted vive adentro de la *"Oxford House"* usted puede recibir

tratamiento del abuso de drogas/alcohol y usted será animado que asiste a unos grupo de apoyo de 12 pasos como de alcohólicos anónimos (AA) y narcóticos anónimos (NA). Dos meses después de la primera entrevista, y su asignación a uno de los dos tipos de "Oxford House" mencionados, le llamaremos para asegurarnos de que tenemos el número y la dirección correcta para contactarlo/a para la entrevista en seis meses.

Antes del punto del mes-6 le llamaremos para preguntarle cuando será un buen tiempo para tener la entrevista. Usted puede terminar la entrevista en persona en su casa, en la Universidad de DePaul, por teléfono, o por cualquier forma que sea más fácil para usted. Si el financiamiento adicional se recibe para continuar el estudio, posiblemente será contactado para saber si está dispuesto a participar en la tercera entrevista en el mes-12. Pediremos su consentimiento verbal para participar en la tercera entrevista. Casi todas las entrevistas implicarán preguntas que hagamos verbalmente y entonces anotaremos sus respuestas. En la primera entrevista, un cuestionario será contestado usando una computadora. Si usted necesita ayuda usando la computadora, le ayudaremos.

Cuáles son los riesgos implicados en participar en este estudio?

La investigación implica la discusión de temas potencialmente delicados con los entrevistadores y es posible que usted se sienta incomodo o inquieto cuando le pidan recordar su abuso de drogas/alcohol o comportamiento criminal pasado o actual. Si las entrevistas le producen cualquier preocupación, el personal de DePaul le ayudará a encontrar un consejero o le ofrecerá una lista de salas de emergencia locales, de hospitales comunitarios, y de clínicas de salud que sirven la región norte de Illinois. Si usted necesita ayuda, le ayudaremos con las referencias.

Otro riesgo es que alguien podría descubrir lo que usted dijo si la información de sus entrevistas sea accidentalmente o equivocadamente hecho público. Sin embargo, esto nunca ha sucedido antes en cualquiera de nuestros proyectos de investigación, y tomaremos medidas para asegurarnos de que sus datos estén protegidos siempre.

Si en cualquier tiempo nos sentimos que hay un niño en peligro del abuso o de negligencia o que usted puede lastimarse o a otros, debemos reportar esta información a las autoridades.

¿Cuáles son los beneficios de mi participación en el estudio?

Usted no se beneficiara personalmente en este estudio. Esperamos que la información que conseguimos del estudio resulte en mejores programas en el futuro para la gente en recuperación.

¿Recibiré un incentivo para participar en este estudio?

Usted recibirá $30.00 dólares en efectivo por sus respuestas en cada entrevista, para un total de $60.00 dólares. Si el financiamiento adicional se concede para que continuemos con el estudio y usted está dispuesto a participar en la tercera entrevista en el mes-12,

usted podría recibir un pago de $30.00 dólares adiciónales, para un total de $90.00 dólares.

¿Puedo decidir no participar?

Sí, usted puede elegir no participar. Aunque usted ahora decidió participar en el estudio, usted puede cambiar de opinión y dejar el estudio en cualquier momento. No habrá consecuencias negativas si usted decide no participar o cambia su decisión en el futuro. ***Si usted decide no participar en este estudio, todavía podrá participar en cualquier programa del tratamiento disponible para usted, incluyendo el "Oxford House"***. En el futuro, si usted decide no participar en el estudio podrá quedarse en "Oxford House".

¿Cómo se protegerá la confidencialidad de los archivos de la investigación?

Los archivos de este estudio serán mantenidos confidenciales. No escribiremos su nombre en los archivos de la investigación, al contrario escribiremos solamente un número de identificación. Solamente el equipo del estudio sabrá cuál es su número de identificación, de modo que alguien fuera a ver los archivos de la investigación, ellos no sabrán que la información es sobre usted.

Cualquier información que podríamos publicar o que compartamos con cualquier persona fuera del equipo de investigación, no incluiremos ninguna información que identifique su nombre u otros identificadores. Además, ninguna información que se presente de parte del estudio será dada a un oficial de probación o a cualquier otra persona.

Finalmente, para ayudarnos a proteger su privacidad, también hemos obtenido un certificado de confidencialidad de los Institutos Nacionales de la Salud. Con este certificado, no podemos ser forzados a revelar la información que puede identificarle, incluso por una citación de la corte, en cualquier procedimiento federal, estatal, o civil local, administrativo, legislativo, u otros procedimientos. Los investigadores utilizarán el certificado para oponerse a cualquier demanda para la información que le identificaría.

El Certificado no puede ser usado para resistir una demanda para información de un personal de Gobierno de los Estados Unidos que es usado para auditar o evaluar proyectos financiados con fondos federales. Usted debe entender que un certificado de confidencialidad no evita que usted revele voluntariamente la información sobre usted o su participación en esta investigación. Si un asegurador, un empresario, u otra persona obtienen su consentimiento para recibir información de la investigación, entonces los investigadores no pueden utilizar el certificado para retener esa información. El certificado de confidencialidad no nos previene divulgar voluntariamente, sin su consentimiento, la información que le identificaría como participante en el proyecto de investigación bajo circunstancias siguientes: abuso de niño y negligencia o intento para lastimarse o a otros.

Algunas personas pueden repasar nuestros archivos para asegurarse de que estamos haciendo lo que debemos hacer. Por ejemplo, el comité de revisión institucional de la

Universidad de DePaul (“Institutional Review Board”) o la agencia de financiamiento para la investigación (el Instituto Nacional en Abuso de Alcohol y Alcoholismo) pueden examinar su información. Si estas agencias examinan nuestros archivos, ellos mantendrán su información confidencial.

¿A quién puedo contactar para más información?

El investigador de la Universidad de DePaul el Dr. Richard Contreras puede ser localizado al (773) 325-4962, o por correo electrónico a rcontrer@depaul.edu, estará disponible para contestar preguntas que tenga en el futuro. Si usted tiene preguntas sobre sus derechos como participante, usted puede contactar a Susan Loess-Perez, Directora de Protecciones en Investigación de la Universidad de DePaul al (312)362-7593 o por correo electrónico a sloesspe@depaul.edu.

Le darán una copia de esta información para sus archivos.

Declaración del consentimiento:

He leído la información antedicha. Todas mis preguntas han sido contestadas. (Marque sólo una opción:)

o Consiento estar en este estudio. o **NO** consiento a estar en este estudio.

Firma: _____

Fecha: _____

Nombre impreso: _____

Responsabilidades del entrevistador/ del reclutador (para el entrevistador/el reclutador a llenar):

El estudio ha sido totalmente explicado a _____ (participante) incluyendo la naturaleza y el propósito de los procedimientos descritos antedicho de la investigación y los riesgos y las ventajas implicadas en su funcionamiento. Como el reclutador/el entrevistador, he hecho las preguntas sobre la comprensión del participante de la forma del consentimiento, y he contestado cualquier pregunta que el participante haya tenido sobre el estudio. Como el investigador, contestaré todas las preguntas futuras lo mejor de mi capacidad. Informaré al participante de cualquier cambio en los procedimientos o los riesgos y las ventajas que puedan ocurrir durante o después del curso del estudio. El participante ha recibido una copia del consentimiento.

Firma de la persona que obtiene el consentimiento:_____

Fecha: _____

Formulario-Persona más Importante

Como parte de este estudio, el equipo de investigación de DePaul deberá ponerse en contacto con mi "persona más importante." Esta es una persona que está cerca de mí y puede darle al equipo de investigación información para contactarme, eso es, si tienen problemas para ponerse en contacto conmigo para el seguimiento de las entrevistas.

Por lo tanto, yo, el participante, _____, doy permiso para que la Universidad de DePaul contacte a:

Nombre: _____

Relación: _____

Número de Celular: _____

Número de Casa: _____

Dirección: _____

Nombre: _____

Relación: _____

Número de Celular: _____

Número de Casa: _____

Dirección: _____

Nombre: _____

Relación: _____

Número de Celular: _____

Número de Casa: _____

Dirección: _____

_____

Nombre: _____

Relación: _____

Número de Celular: _____

Número de Casa: _____

Dirección: _____

_____

Nombre: _____

Relación: _____

Número de Celular: _____

Número de Casa: _____

Dirección: _____

_____

Nombre: _____

Relación: _____

Número de Celular: _____

Número de Casa: _____

Dirección: _____

_____

(Como se indica en el registro de seguimiento)

Los investigadores se pondrán en contacto con esta persona (a través por teléfono, o por último recurso, en persona) en el mes 6, y posiblemente en el mes 12, si el equipo de investigación tiene problemas para encontrarme. Puedo retirar mi consentimiento para participar en este estudio, incluyendo mi permiso para contactar a esta persona, en cualquier momento. Por favor, hable con la “persona más importante,” para que puedan saber que usted está participando en un estudio y si es necesario, le llamaremos para preguntarle cómo podíamos contactarlo.

Firma del participante: _____ Fecha _____

Firma del testigo: _____ Fecha _____

Formulario de Seguimiento de Información

Como parte de este estudio, el equipo de investigación de DePaul va a tener que localizarme para la(s) entrevista(s) que siguen. Tengo la oportunidad de abandonar el estudio en cualquier momento si notifico al equipo de DePaul [Richard Contreras]. Sin embargo, mientras que sea parte del estudio, el equipo de DePaul se pondrá en contacto con el presidente del "Oxford House" y otras personas que he enumerado como "personas importantes" en mi vida, si el equipo de investigación no puede encontrarme o localizarme. Si el equipo de DePaul tiene problemas localizándome, los investigadores también trataran de obtener esta información de diferentes instituciones que también puedan tener mi información de contacto correspondiente (por ejemplo, centros de tratamiento o centros penitenciarios). Durante el período del estudio, si me salgo del "Oxford House" el equipo de DePaul se pondrá en contacto con el Presidente de "Oxford House" y otros funcionarios para determinar las razones porqué me fui de "Oxford House".

Por lo tanto, yo, el participante, _____, le doy al equipo de DePaul el permiso para llamar a cualquiera de las personas que figuran en el registro de seguimiento o en la lista de "personas importantes," y tener acceso a mi información de las instituciones, servicios, o las bases de datos que pueden tener información que puedan ayudar a localizarme tal vez como centros médicos, centros de tratamiento penitenciarios, el Departamento de Vehículos, etc. Yo le doy permiso al equipo de DePaul para que se contacten con el equipo de Oxford House y con el Presidente de "Oxford House" u otros funcionarios para decidir que era las razones por las que me salí de "Oxford House".

Permiso para contactar estas personas o instituciones:

Firma del participante: _____ Fecha: _____

Firma del testigo: _____ Fecha: _____

Appendix B

Demographic Questionnaire
(English Version)

Demographic Questionnaire

1. Participant ID Number: _____

2. Date of Administration: _____

3. Treatment Setting Name: _____

4. Interviewer: _____

5. What is your age? _____

6. What is your gender?

_____ Female _____ Male

7. To what racial group do you belong?

_____Hispanic/Latina/o
_____White
_____Black or African American
_____American Indian or Alaskan Native
_____Asian
_____Native Hawaiian or Pacific Islander
_____Middle Eastern Descent
_____Other (specify_____)
_____Multi-racial

8. Have you had any substance abuse treatment previously (i.e., 12-step program, at least a three day detoxification, and/or one-on-one sessions with a counselor)?

_____Yes _____No

9. Are you currently seeking treatment for your substance abuse?

_____Yes _____No

10. In your life time, how many times (total) have you been incarcerated? _____

11. Do you have a high school diploma or GED?
_____Yes _____No

12. Where were you born? _____

13. If you were born outside of the United States, how many years have you lived in the United States for?

_____

14. Where was your mother born? _____

15. Where was your father born? _____

16. What types of treatment have you received in the past for substance abuse?
_____12 step program
_____One-on-one sessions with a counselor
_____Group sessions with a counselor
_____Detoxification (medical or other)
_____Other (specify_____ other than current setting)

17. In your current treatment setting, were you mandated to participate?
_____Yes _____No

18. How were you referred to your current treatment setting?
_____ Individual (e.g. self, family member, friend)
_____ Substance Abuse Care Provider
_____ Other Health Care Provider (e.g. physician)
_____ School/Educational
_____ Employer/EAP
_____ Other Community Referral
_____ Court or Criminal Justice

Cuestionario Demográfico

(Spanish Version)

1. Número de ID del participante _____

2. Fecha de administración: _____

3. Tipo de tratamiento: _____

4. Entrevistador: _____

5. ¿Cuántos años tiene? _____

6. ¿Cual es su género?
_____Mujer _____Hombre

7. A qué grupo racial pertenece usted:
_____hispano/Latina/o
_____blanco
_____negro o afroamericano
_____indio americano o nativo de Alaska
_____asiático
_____hawaiano nativo o isleño del pacífico
_____del Oriente Medio
_____Otro (especifique _____)
_____Multicultural

8. ¿Ha tenido otro tratamiento por problemas de abuso de sustancias? Por ejemplo, el programa de 12 pasos de AA, al menos 3 días en un programa de desintoxicación, o sesiones individuales con un consejero?
_____sí _____no

9. ¿En este momento está buscando tratamiento por sus problemas de abuso de sustancias?
_____sí _____no

10. ¿En su vida, cuántas veces ha estado encarcelado? _____

11. ¿Tiene usted un diploma de preparatoria o el equivalente de GED?
_____sí _____no

12. ¿Cual es su país de origen? _____

13. ¿Si usted nació en otro país, cuantos años ha vivido en los Estados Unidos?
_____

14. ¿Dónde es el lugar de nacimiento de su madre? _____

15. ¿Dónde es el lugar de nacimiento de su padre? _____

16. Indique que programas de tratamiento ha recibido para los problemas de abuso de sustancias
_____programa de los 12 pasos
_____uno a uno períodos de sesiones con un consejero
_____sesiones de grupo con un consejero
_____desintoxicación (médico u otro)
_____otro programa (especifique _____)

17. ¿Le forzaron a participar en su tratamiento?
_____sí _____no

18. ¿Cómo fue canalizado a su tratamiento actual?
_____ Individual (e.g. sí mismo, miembro de la familia, amigo)
_____ proveedor del programa de abuso de sustancias
_____ proveedor de otros servicios médicos (e.g. medico familiar)
_____ escuela/institución educativa
_____ Empleador/programa de asistencia del empleo
_____ otro tipo de referencia de comunidad
_____ Corte o justicia criminal

Appendix C

Bidimensional Acculturation Scale
(English Version)

Bi-dimensional Acculturation Scale for Hispanics (English Version)

1. How often do you speak English?
___almost always ___often ___sometimes ___never

2. How often do you speak in English with your friends?
___almost always ___often ___sometimes ___never

3. How often do you think in English?
___almost always ___often ___sometimes ___never

4. How often do you speak Spanish?
___almost always ___often ___sometimes ___never

5. How often do you speak in Spanish with your friends?
___almost always ___often ___sometimes ___never

6. How often do you think in Spanish?
___almost always ___often ___sometimes ___never

7. How often do you watch television programs in English?
___almost always ___often ___sometimes ___never

8. How often do you listen to radio programs in English?
___almost always ___often ___sometimes ___never

9. How often do you listen to music in English?
___almost always ___often ___sometimes ___never

10. How often do you watch television programs in Spanish?
___almost always ___often ___sometimes ___never

11. How often do you listen to radio programs in Spanish?
___almost always ___often ___sometimes ___never

12. How often do you listen to music in Spanish?
___almost always ___often ___sometimes ___never

---

13. How well do you speak English?
___very well ___well ___poorly ___very poorly

14. How well do you read in English?
___very well ___well ___poorly ___very poorly

15. How well do you understand television programs in English?
___very well ___well ___poorly ___very poorly

16. How well do you understand radio programs in English?
___very well ___well ___poorly ___very poorly

17. How well do you write in English?
___very well ___well ___poorly ___very poorly

18. How well do you understand music in English?
___very well ___well ___poorly ___very poorly

19. How well do you speak Spanish?
___very well ___well ___poorly ___very poorly

20. How well do you read in Spanish?
___very well ___well ___poorly ___very poorly

21. How well do you understand television programs in Spanish?
___very well ___well ___poorly ___very poorly

22. How well do you understand radio programs in Spanish?
___very well ___well ___poorly ___very poorly

23. How well do you write in Spanish?
___very well ___well ___poorly ___very poorly

24. How well do you understand music in Spanish?
___very well ___well ___poorly ___very poorly

Bidimensional Acculturation Scale
(Spanish Version)

Escala de Aculturacion Bidimensional (EAB)

1. ¿Con qué frecuencia habla usted inglés?
___casi siempre ___a menudo ___a veces ___ nunca

2. ¿Con qué frecuencia habla usted en inglés con sus amigos?
___casi siempre ___a menudo ___a veces ___ nunca

3. ¿Con qué frecuencia piensa usted en inglés?
___casi siempre ___a menudo ___a veces ___ nunca

4. ¿Con qué frecuencia habla usted español?
___casi siempre ___a menudo ___a veces ___ nunca

5. ¿Con qué frecuencia habla usted en español con sus amigos?
___casi siempre ___a menudo ___a veces ___ nunca

6. ¿Con qué frecuencia piensa usted en español?
___casi siempre ___a menudo ___a veces ___ nunca

7. ¿Con qué frecuencia ve usted programas de televisión en inglés?
___casi siempre ___a menudo ___a veces ___ nunca

8. ¿Con qué frecuencia escucha usted programas de radio en inglés?
___casi siempre ___a menudo ___a veces ___ nunca

9. ¿Con qué frecuencia escucha usted música en inglés?
___casi siempre ___a menudo ___a veces ___ nunca

10. ¿Con qué frecuencia ve usted programas de televisión en español?
___casi siempre ___a menudo ___a veces ___ nunca

11. ¿Con qué frecuencia escucha usted programas de radio en español?
___casi siempre ___a menudo ___a veces ___ nunca

12. ¿Con qué frecuencia escucha usted música en español?
___casi siempre ___a menudo ___a veces ___ nunca

13. ¿Qué tan bien habla usted inglés?
___muy bien ___bien ___mal ___muy mal

14. ¿Qué tan bien lee usted en inglés?
___muy bien ___bien ___mal ___muy mal

15. ¿Qué tan bien entiende usted los programas de televisión en inglés?
___muy bien ___bien ___mal ___muy mal

16. ¿Qué tan bien entiende usted los programas de radio en inglés?
___muy bien ___bien ___mal ___muy mal

17. ¿Qué tan bien escribe usted en inglés?
___muy bien ___bien ___mal ___muy mal

18. ¿Qué tan bien entiende usted música en inglés?
___muy bien ___bien ___mal ___muy mal

19. ¿Qué tan bien habla usted español?
___muy bien ___bien ___mal ___muy mal

20. ¿Qué tan bien lee usted en español?
___muy bien ___bien ___mal ___muy mal

21. ¿Qué tan bien entiende usted los programas de televisión en español?
___muy bien ___bien ___mal ___muy mal

22. ¿Qué tan bien entiende usted los programas de radio en español?
___muy bien ___bien ___mal ___muy mal

23. ¿Qué tan bien escribe usted en español?
___muy bien ___bien ___mal ___muy mal

24. ¿Qué tan bien entiende usted música en español?
___muy bien ___bien ___mal ___muy mal

Appendix D

Psychological Acculturation Scale
(English Version)

Psychological Acculturation Scale – English Version
(Tropp, Erkut, Garcia Coll, Alarcon, & Vazquez-Garcia, 1999)

1. With what group of people do you feel you **share most of your beliefs and values**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

2. With which group of people do you feel you **have the most in common**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

3. With which group of people do you **feel most comfortable**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

4. In your opinion, which group of people **best understands your ideas** (your way of thinking)?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

5. Which culture do you **feel proud to be a part of**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

6. In what culture do you know **how things are done** and **feel that you can do them easily**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

7. In what culture do you **feel confident you know how to act**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

8. In your opinion, which group of people **do you understand best**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latina/os — Equally with Hispanics/Latina/os and Anglos (Americans) — Only with Anglos (Americans)

9. In what culture do you know **what is expected of a person in various situations**?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latinas/os — Equally with Hispanics/Latinas/os and Anglos (Americans) — Only with Anglos (Americans)

10. Which culture do you **know the most about** (for example: its history, traditions, and customs)?

1----------2----------3----------4----------5----------6---------7----------8----------9
Only with Hispanics/Latinas/os — Equally with Hispanics/Latinas/os and Anglos (Americans) — Only with Anglos (Americans)

Psychological Acculturation Scale
(Spanish Version)

Psychological Acculturation Scale – Spanish Version
(Tropp, Erkut, Garcia Coll, Alarcon, & Vazquez-Garcia, 1999)

1. ¿Con que grupo de personas siente que comparte la mayoría de sus creencias y valores?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

2. ¿Con que grupo de personas siente que tiene lo mas en común?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

3. ¿Con que grupo de personas se siente mas cómodo (a)?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

4. ¿En su opinión, que grupo de personas mejor entiende sus ideas (su forma de pensar)?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

5. ¿De qué cultura se siente orgulloso (a) de ser miembro?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

6. ¿En qué cultura sabe cómo se hacen las cosas y siente que puede hacerlas con facilidad?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

7. ¿En qué cultura se siente seguro (a) de que sabe cómo comportarse?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

8. ¿En su opinión, a qué grupo de personas entiende mejor?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

9. ¿En qué cultura sabe lo que se espera de una persona en varias situaciones?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

10. ¿De qué cultura conoce más (por ejemplo: su historia, sus tradiciones, y sus costumbres)?

1----------2----------3----------4----------5----------6---------7----------8----------9
Solo con Latinas/os Hispanas/os | Con Latinas/os y Anglos por igual | Solo con Anglos (Americanos)

Appendix E

Important People Inventory
(English Version)

Important People Inventory

The following questions refer to the people, who are at least 12 years old, that have been important to you and with whom you've had contact during the past THREE months. These people may be family members, friends, people from work, or anyone that you see as having had a significant impact on your life, regardless of whether or not you liked them. Should you have any questions please don't hesitate to ask.

NAME OF PERSON?	1. First name and initial of last name	2. First name and initial of last name	3. First name and initial of last name	4. First name and initial of last name
RELATIONSHIP WITH PERSON?	1 = spouse 2 = children 3 = parent 4 = sibling 5 = other family 6 = ex-intimate 7 = boy/girlfriend 8 = work friend 9 = AA/NA friend 10 = other friend 11 = coworker 12 = other	1 = spouse 2 = children 3 = parent 4 = sibling 5 = other family 6 = ex-intimate 7 = boy/girlfriend 8 = work friend 9 = AA/NA friend 10 = other friend 11 = coworker 12 = other	1 = spouse 2 = children 3 = parent 4 = sibling 5 = other family 6 = ex-intimate 7 = boy/girlfriend 8 = work friend 9 = AA/NA friend 10 = other friend 11 = coworker 12 = other	1 = spouse 2 = children 3 = parent 4 = sibling 5 = other family 6 = ex-intimate 7 = boy/girlfriend 8 = work friend 9 = AA/NA friend 10 = other friend 11 = coworker 12 = other
SEX OF PERSON?	M or F	M or F	M or F	M or F
IS THIS PERSON AN OXFORD HOUSE RESIDENT?	0 = no 1 = yes	0 = no 1 = yes	0 = no 1 = yes	0 = no 1 = yes
HOW LONG HAVE YOU KNOWN HIM OR HER?	___Years ___ Months	___Years ___ Months	___Years ___ Months	___Years ___ Months
DURING THE PAST THREE MONTHS, HOW FREQUENTLY HAVE YOU BEEN IN CONTACT WITH…?	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in the past 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in the past 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in the past 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in the past 6 months 0 = not in the past 6 months
IS THIS PERSON GENERALLY SUPPORTIVE OF YOU?	0 = no 1 = yes	0 = no 1 = yes	0 = no 1 = yes	0 = no 1 = yes
DRINKING STATUS OF PERSON?	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering

HOW OFTEN DOES THIS PERSON DRINK ALCOHOL?	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months
WHEN THIS PERSON USES ALCOHOL, WHAT IS THE MOST THAT HE/SHE USES IN A SINGLE DAY?	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't drink	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't drink	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't drink	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't drink

DRUG USE STATUS OF PERSON?	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering	5 = heavy user 4 = moderate user 3 = light user 2 = abstainer 1 = recovering
HOW OFTEN DOES THIS PERSON USE DRUGS?	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months	7 = daily 6 = 3-6 times per wk 5 = 1-2 times per wk 4 = every other wk 3 = about once a month 2 = less than monthly 1 = once in 6 months 0 = not in the past 6 months
WHEN THIS PERSON USES DRUGS, WHAT IS THE MOST THAT HE/SHE USES IN A SINGLE DAY?	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't use drugs	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't use drugs	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't use drugs	4 = 10 or more times 3 = 6-9 times 2 = 3-5 times 1 = 1-2 times 0 = doesn't use drugs

Your Most Important People Inventory

<u>Of the people you listed on the previous sheets</u>, **<u>please name the four (4)</u>** that you think have been **<u>the most important</u>** to you **<u>during the past 3 months</u>**. These would be the people who have had the greatest impact on your life, whether you liked them or not. Please answer the following questions as they pertain to the person you listed by circling the number.

OF THOSE PEOPLE PREVIOUSLY LISTED, WHO ARE THE FOUR MOST IMPORTANT?	**1. First name and initial of last name**	**2. First name and initial of last name**	**3. First name and initial of last name**	**4. First name and initial of last name**
HOW MUCH HAVE YOU LIKED THIS PERSON?	**7** = Totally liked **6** = Very much **5** = Quite a bit **4** = Mixed feelings **3** = Disliked **2** = Disliked a lot **1** = Totally disliked	**7** = Totally liked **6** = Very much **5** = Quite a bit **4** = Mixed feelings **3** = Disliked **2** = Disliked a lot **1** = Totally disliked	**7** = Totally liked **6** = Very much **5** = Quite a bit **4** = Mixed feelings **3** = Disliked **2** = Disliked a lot **1** = Totally disliked	**7** = Totally liked **6** = Very much **5** = Quite a bit **4** = Mixed feelings **3** = Disliked **2** = Disliked a lot **1** = Totally disliked
HOW IMPORTANT HAS THIS PERSON BEEN TO YOU?	**6** = Extremely **5** = Very **4** = Important **3** = Somewhat **2** = Not very **1** = Not at all	**6** = Extremely **5** = Very **4** = Important **3** = Somewhat **2** = Not very **1** = Not at all	**6** = Extremely **5** = Very **4** = Important **3** = Somewhat **2** = Not very **1** = Not at all	**6** = Extremely **5** = Very **4** = Important **3** = Somewhat **2** = Not very **1** = Not at all
HOW HAS/OR HOW WOULD THIS PERSON REACT TO YOUR DRINKING?	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave
HOW HAS/OR HOW WOULD THIS PERSON REACT TO YOUR DRUG USE?	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave
HOW HAS/OR HOW WOULD THIS PERSON REACT TO YOUR *<u>NOT</u>* DRINKING?	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave
HOW HAS/OR HOW WOULD THIS PERSON REACT TO YOUR *<u>NOT</u>* USING DRUGS?	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave	**5** = Encouraged **4** = Accepted **3** = Neutral **2** = Didn't accept **1** = Left, or made you leave

HOW DID/DOES THIS PERSON FEEL ABOUT YOUR LIVING IN AN OXFORD HOUSE?	**5** = Supports my getting treatment in O.H. **4** = Supports my getting treatment, though might prefer I did it differently **3** = Neutral / doesn't say **2** = Mixed: Sometimes supports, sometimes opposes **1** = Opposes	**5** = Supports my getting treatment in O.H. **4** = Supports my getting treatment, though might prefer I did it differently **3** = Neutral / doesn't say **2** = Mixed: Sometimes supports, sometimes opposes **1** = Opposes	**5** = Supports my getting treatment in O.H. **4** = Supports my getting treatment, though might prefer I did it differently **3** = Neutral / doesn't say **2** = Mixed: Sometimes supports, sometimes opposes **1** = Opposes	**5** = Supports my getting treatment in O.H. **4** = Supports my getting treatment, though might prefer I did it differently **3** = Neutral / doesn't say **2** = Mixed: Sometimes supports, sometimes opposes **1** = Opposes

Important People Inventory
(Spanish Version)

Inventario de Personas Importantes

Las siguientes preguntas se refieren a las personas, que **por lo menos tienen 12 años de edad**, que han sido importantes para usted, y con las cuales ha tenido contacto en los **últimos 3 meses**. Estas personas pueden ser miembros de su familia, amigos, compañeros de trabajo, o cualquier otra persona que usted cree que había tenido un impacto importante en su vida, aunque estas personas no le agradaban. Si usted tiene alguna pregunta, por favor siéntese cómodo en preguntar.

¿NOMBRE DE LA PERSONA?	**1. Primer nombre e inicial de apellido**	**2. Primer nombre e inicial de apellido**	**3. Primer nombre e inicial de apellido**	**4. Primer nombre e inicial de apellido**
¿RELACIÓN CON LA PERSONA?	**1** = esposo/a **2** = hijo/hija **3** = padre/madre **4** = hermano/a **5** = otro familia **6** = ex-íntimos **7** = novio/novia **8** = amigo de trabajo **9** = AA/NA amigo **10** = otro amigo **11** = compañero de trabajo **12** = otra relación	**1** = esposo/a **2** = hijo/hija **3** = padre/madre **4** = hermano/a **5** = otro familia **6** = ex-íntimos **7** = novio/novia **8** = amigo de trabajo **9** = AA/NA amigo **10** = otro amigo **11** = compañero de trabajo **12** = otra relación	**1** = esposo/a **2** = hijo/hija **3** = padre/madre **4** = hermano/a **5** = otro familia **6** = ex-íntimos **7** = novio/novia **8** = amigo de trabajo **9** = AA/NA amigo **10** = otro amigo **11** = compañero de trabajo **12** = otra relación	**1** = esposo/a **2** = hijo/hija **3** = padre/madre **4** = hermano/a **5** = otro familia **6** = ex-íntimos **7** = novio/novia **8** = amigo de trabajo **9** = AA/NA amigo **10** = otro amigo **11** = compañero de trabajo **12** = otra relación
¿SEXO DE LA PERSONA?	**M** o **H**	**M** o **H**	**M** o **H**	**M** o **H**
¿ES ESTA PERSONA RESIDENTE DE LA CASA OXFORD?	**0** = no **1** = sí	**0** = no **1** = sí	**0** = no **1** = sí	**0** = no **1** = sí
¿CUÁNTO TIEMPO CONOCE A ESTA PERSONA?	___Años ___ Meses	___Años ___ Meses	___Años ___ Meses	___Años ___ Meses
¿EN LOS ÙLTIMOS TRES MESES, CON QUE FRECUENCIA HA ESTADO EN CONTACTO CON ESTA PERSONA?	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses
¿ESTA PERSONA LE APOYA GENERALMENTE?	**0** = no **1** = sí	**0** = no **1** = sí	**0** = no **1** = sí	**0** = no **1** = sí
¿EL NIVEL DE USO DE ALCOHOL DE ESTA PERSONA?	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose

¿CON QUÉ FREQUENCIA ESTA PERSONA CONSUME ALCOHOL?	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1 =** una vez en los últimos seis meses **0 =** ninguna vez en los pasados seis meses	**7 =** diario **6 =** 3-6 veces por semana **5 =** 1-2 veces por semana **4 =** cada dos semanas **3 =** como una vez al mes **2 =** menos de una vez al mes **1 =** una vez en los últimos seis meses **0 =** ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses
¿CUANDO ESTA PERSONA CONSUME ALCOHOL, CUÁL ES LO MÁXIMO QUE EL/ELLA CONSUME EN UN DÌA?	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no bebe	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no bebe	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no bebe	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no bebe

¿EL NIVEL DE USO DE DROGAS DE ESTA PERSONA?	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose	**5** = mucho uso **4** = uso moderado **3** = poco uso **2** = se abstiene **1** = recuperándose
¿CON QUE FRECUENCIA ESTA PERSONA USA LAS DROGAS?	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1 =** una vez en los últimos seis meses **0 =** ninguna vez en los pasados seis meses	**7 =** diario **6 =** 3-6 veces por semana **5 =** 1-2 veces por semana **4 =** cada dos semanas **3 =** como una vez al mes **2 =** menos de una vez al mes **1 =** una vez en los últimos seis meses **0 =** ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses	**7** = diario **6** = 3-6 veces por semana **5** = 1-2 veces por semana **4** = cada dos semanas **3** = como una vez al mes **2** = menos de una vez al mes **1** = una vez en los últimos seis meses **0** = ninguna vez en los pasados seis meses
¿CUANDO ESTA PERSONA USA DROGA, CUAL ES LO MAXIMO QUE EL/ELLA USA EN UN DÌA?	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no usa drogas	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no usa drogas	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no usa drogas	**4** = 10 o más veces **3** = 6-9 veces **2** = 3-5 veces **1** = 1-2 veces **0** = no usa drogas

Continue en la página siguiente

Inventario de Su Gente Más Importante

De las personas que mencionó en las páginas anteriores, por favor nombre las cuatro (4) que piensas que han sido las **más importantes** para usted en los **últimos 3 meses**. Estas son las personas que han tenido el mayor impacto en su vida, aunque no sean de su agrado. Por favor responda las preguntas que pertenezca a la persona que mencionó haciendo un círculo en el número.

¿DE LAS PERSONAS ANTERIORMENTE MENCIONADAS, CUALES SON LAS CUATRO MÁS IMPORTANTES?	1. Primer nombre e inicial de apellido	2. Primer nombre e inicial de apellido	3. Primer nombre e inicial de apellido	4. Primer nombre e inicial de apellido
¿QUE TANTO LE AGRADA ESTA PERSONA?	**7**= Agrada totalmente **6**= Mucho **5**= Un poco **4**= Sentimientos encontrados **3**=Me desagrada **2**=Desagrada mucho **1**=Totalmente me desagrada	**7**= Agrada totalmente **6**= Mucho **5**= Un poco **4**= Sentimientos encontrados **3**=Me desagrada **2**=Desagrada mucho **1**=Totalmente me desagrada	**7**= Agrada totalmente **6**= Mucho **5**= Un poco **4**= Sentimientos encontrados **3**=Me desagrada **2**=Desagrada mucho **1**=Totalmente me desagrada	**7**= Agrada totalmente **6**= Mucho **5**= Un poco **4**= Sentimientos encontrados **3**=Me desagrada **2**=Desagrada mucho **1**=Totalmente me desagrada
¿QUE TAN IMPORTANTE HA SIDO ESTA PERSONA PARA TI?	**6**=Extremadamente **5**=Mucho **4**=Importante **3**=Más o menos **2**=No mucho **1**=Para nada	**6**=Extremadamente **5**=Mucho **4**=Importante **3**=Más o menos **2**=No mucho **1**=Para nada	**6**=Extremadamente **5**=Mucho **4**=Importante **3**=Más o menos **2**=No mucho **1**=Para nada	**6**=Extremadamente **5**=Mucho **4**=Importante **3**=Más o menos **2**=No mucho **1**=Para nada
¿CÒMO ESTA PERSONA REACIONÒ O REACIONARÌA AL VERTE TOMAR ALCOHOL?	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar
¿CÒMO ESTA PERSONA REACIONÒ O REACIONARÌA A SU USO DE DROGAS?	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar
¿CÒMO ESTA PERSONA REACIONÒ O REACIONARÌA AL VER QUE NO TOMAS ALCOHOL?	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar

¿CÒMO ESTA PERSONA REACIONÒ O REACIONARÌA AL VER QUE <u>NO</u> CONSUME DROGAS?	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar	**5**=Me motivaría **4**=Acepta **3**=Neutral **2**=No aceptaría **1**=Se retira, o me haría retirar
¿CÒMO SE SIENTE O SE SENTIRÌA ESTA PERSONA AL SABER QUE VIVES EN UNA DE LAS "Oxford House"?	**5**=Apoya mi tratamiento en O.H **4**=Apoya que estoy recibiendo tratamiento, pero preferiría que fuese diferente **3**=Neutral / No dice **2**=Confundido: Algunas veces apoya, otras desaprueba. **1**=Se Opone	**5**=Apoya mi tratamiento en O.H **4**=Apoya que estoy recibiendo tratamiento, pero preferiría que fuese diferente **3**=Neutral / No dice **2**=Confundido: Algunas veces apoya, otras desaprueba. **1**=Se Opone	**5**=Apoya mi tratamiento en O.H **4**=Apoya que estoy recibiendo tratamiento, pero preferiría que fuese diferente **3**=Neutral / No dice **2**=Confundido: Algunas veces apoya, otras desaprueba. **1**=Se Opone	**5**=Apoya mi tratamiento en O.H **4**=Apoya que estoy recibiendo tratamiento, pero preferiría que fuese diferente **3**=Neutral / No dice **2**=Confundido: Algunas veces apoya, otras desaprueba. **1**=Se Opone

Appendix F

House Processes Questionnaire
(English Version)

OXFORD HOUSE PROCESSES QUESTIONNAIRE

WAVE: 1 2 3 4 5
INTERVIEWER: _____ PARTICIPANT: _____

DATE OF INTERVIEW: _____ HOUSE: _____

I'D LIKE TO ASK YOU SOME QUESTIONS ABOUT HOUSE POLICIES

1. How often does your House hold business meetings?

_____EVERY TWO WEEKS
_____ONCE A WEEK
_____SEVERAL TIMES A WEEK
_____ONCE A DAY
_____OTHER (Please specify) _____

2. Are there any consequences for people who miss the meetings?
_____YES _____NO

3. Are there any consequences for people who are late to business meetings or leave early?
_____YES _____NO

4. Do new residents at your House receive a handbook that outlines procedures, available services, policies, etc.?
_____YES _____NO

5. Is there an orientation for new residents at your House?
_____YES _____NO

6. Are rules and regulations posted in a visible space?
_____YES _____NO

7. Do residents eat family style?
_____YES _____NO

8. How are house chores managed in your House?

VOLUNTEERED, EACH WEEK 1
VOLUNTEERED, EACH MONTH 2
ELECTED, EACH WEEK..... 3
ELECTED, EACH MONTH 4
APPOINTED 5
OTHER (specify)....6
_____

9. Is there a curfew at your house?
_____YES _____NO

10. Are there rules for residents who spend a night out of the house?
_____YES _____NO

11. Are there rules about having overnight guests in residents' rooms?
_____YES _____NO

12. How often do you cook ethnic foods at the house?
_____DAILY
_____SEVERAL TIMES A WEEK
_____ONCE A WEEK
_____EVERY 2-3 WEEKS
_____ONCE A MONTH
_____LESS THAN ONCE A MONTH

13. How often do you listen to music in Spanish at the house?
_____DAILY
_____SEVERAL TIMES A WEEK
_____ONCE A WEEK
_____EVERY 2-3 WEEKS
_____ONCE A MONTH
_____LESS THAN ONCE A MONTH

14. How often do you watch TV in Spanish at the house?
_____DAILY
_____SEVERAL TIMES A WEEK
_____ONCE A WEEK
_____EVERY 2-3 WEEKS
_____ONCE A MONTH
_____LESS THAN ONCE A MONTH

15. Do you celebrate Hispanic/Latina/o holidays at the house?
_____YES _____NO

If yes, which ones_____

_____

_____

NOW, I'D LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR EXPERIENCES IN YOUR HOUSE.

1. In the past 6 MONTHS, did you hold an elected position in your House? ____YES ____NO
If yes, what position(s) _____

What impact did these positions have on your recovery? (circle one)
Very helpful Helpful Neutral Not helpful Very unhelpful

2. In the past 6 MONTHS, how much time on average have you spent on house chores per week? ____

What impact did chores have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

3. In the past 6 MONTHS, has anyone in your house helped you with child care? ____YES ____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

4. In the past 6 MONTHS, have you participated in social activities with other residents? ____YES
____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

5. In the past 6 MONTHS, have you talked to another resident about problems in your life? ____YES
____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

6. In the past 6 MONTHS, have you received advice on a personal problem from another resident of your house?
____YES ____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

7. In the past 6 MONTHS, have you talked to another house resident about your addiction or recovery program? ____YES
____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

8. In the past 6 MONTHS, have you received help finding a job from another house resident? ____YES
____NO
If so, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

9. In the past 6 MONTHS, have you received help finding any community services from other house residents? ____YES
____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

10. In the past 6 MONTHS, have residents helped you with any other needs such as transportation, errands, etc?
____YES ____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

11. In the past 6 MONTHS, have other residents given you parenting advice or suggestions? ____YES ____NO

If yes, what impact has this had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

12. In the past 6 MONTHS, have you participated on one-on-one meetings with other house residents? ____YES
____NO

If yes, what impact have these meetings had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

13. In the past 6 MONTHS, have you received any fines?
___YES ___NO

If yes, what impact have these fines had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

14. In the past 6 MONTHS, have you been confronted by house members regarding your behavior in the house? ____YES
____NO

If yes, what impact have these experiences had on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

15. In the past 6 MONTHS, have you received a “contract” from house members? ____YES ____NO

If yes, what impact did this contract have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

16. In the past 6 MONTHS, have you had the opportunity to help other house members with a personal problem? ____YES ____NO

If yes, what impact did these experiences have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

17. In the past 6 MONTHS, have you had the opportunity to help other house members with their recovery? ____YES ____NO

If yes, what impact did these experiences have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

18. In the past 6 MONTHS, have you had the opportunity to help other house members to find a job or community services? ____YES ____NO

If yes, what impact did these experiences have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

19. In the past 6 MONTHS, have you had the opportunity to help other house members with parenting or child-care? ____YES ____NO

If yes, what impact did these experiences have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

20. In the past 6 MONTHS, have you attended a chapter meeting?
____YES ____NO

If yes, what impact did these experiences have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

21. In the past 6 MONTHS, have you held any leadership positions in Oxford House at the chapter, state or national level? ____YES ____NO

If yes, what impact did these experiences have on your recovery?
Very helpful Helpful Neutral Not helpful Very unhelpful

NOW, I'D LIKE TO ASK YOU SOME QUESTIONS ABOUT RELATIONSHIPS IN THE HOUSE

1. The members of the house encourage communication in either English or Spanish, depending on residents' comfort level (circle one)
Strongly Disagree Disagree Neutral Agree Strongly Agree

2. House residents treat each other with dignity and respect
Strongly Disagree Disagree Neutral Agree Strongly Agree

3. Relationships among house residents are valued
Strongly Disagree Disagree Neutral Agree Strongly Agree

4. House members understand the way I think
Strongly Disagree Disagree Neutral Agree Strongly Agree

5. Residents confront each other in a respectful manner
Strongly Disagree Disagree Neutral Agree Strongly Agree

6. Family members are encouraged to support residents' recovery
Strongly Disagree Disagree Neutral Agree Strongly Agree

7. House members respect my cultural values and traditions
Strongly Disagree Disagree Neutral Agree Strongly Agree

8. I feel connected to the other residents
Strongly Disagree Disagree Neutral Agree Strongly Agree

9. I feel comfortable with the members of my House
Strongly Disagree Disagree Neutral Agree Strongly Agree

10. I understand what is expected of me in the House
Strongly Disagree Disagree Neutral Agree Strongly Agree

What are your feelings about how the people in your Oxford House have dealt with your cultural values and beliefs.

_____

_____

_____

_____

House Processes Questionnaire
(Spanish Version)

CUESTIONARIO del PROCESO de OXFORD HOUSE

Serie: 1 2 3 4 5
ENTREVISTADOR: _____
PARTICIPANTE: _____

FECHA DE LA ENTREVISTA: _____
CASA: _____

QUISIERA HACERLE ALGUNAS PREGUNTAS ACERCA DE POLÍTICAS de la CASA

1. ¿Cuántas veces en su casa tienen reuniones de negocios?

_____CADA DOS SEMANAS
_____UNA VEZ POR SEMANA
_____VARIAS VECES POR SEMANA
_____UNA VEZ AL DÍA
_____ OTRO (especifique por favor)

2. ¿Hay consecuencias para la gente que falta las reuniones?

_____SI _____NO

3. ¿Hay consecuencias para las personas que llegan tarde a las reuniones de negocios o si se van temprano?

_____SI _____NO

4. ¿Los residentes de la casa reciben un manual que contiene los procedimientos, servicios disponibles, políticas, etc.?

_____SI _____NO

5. ¿Hay una orientación para los nuevos residentes de su casa?

_____SI _____NO

6. ¿Hay reglas y las regulaciones puestas en un espacio visible?

_____SI _____NO

7. ¿Los residentes comen como si fueran familia?

_____SI _____NO

8. ¿Cómo manejan los queháceres en su casa?

VOLUNTARIAMENTE, CADA SEMANA 1
VOLUNTARIAMENTE, CADA MES 2
ELEGIDO, CADA SEMANA 3
ELEGIDO, CADA MES 4
DESIGNADO 5
OTRO (especifique) ……..6

9. ¿Hay un toque de queda en su casa?
_____SI _____NO

10. ¿Hay reglas para los residentes que pasan una noche fuera de la casa?
_____SI _____NO

11. ¿Hay reglas sobre tener huéspedes de noche en los cuartos de los residentes?
_____SI _____NO

12. ¿Cuántas veces usted cocina alimentos étnicos en la casa?
_____TODOS LOS DIAS
_____VARIAS VECES POR SEMANA
_____UNA VEZ A LA SEMANA
_____CADA 2-3 SEMANAS
_____UNA VEZ AL MES
_____MENOS DE UNA VEZ AL MES

13. ¿Cuántas veces usted escucha música en español en la casa?
_____TODOS LOS DIAS
_____VARIAS VECES POR SEMANA
_____UNA VEZ A LA SEMANA
_____CADA 2-3 SEMANAS
_____UNA VEZ AL MES
_____MENOS DE UNA VEZ AL MES

14. ¿Cuántas veces usted ve la televisión en español en la casa?
_____TODOS LOS DIAS
_____VARIAS VECES POR SEMANA
_____UNA VEZ A LA SEMANA
_____CADA 2-3 SEMANAS
_____UNA VEZ AL MES
_____MENOS DE UNA VEZ AL MES

15. ¿Usted celebra festividades Hispanas/Latinas en la casa?

____SI ____NO

Si sí, cuales_____
_____

_____

AHORA, QUISIERA HACERLE ALGUNAS PREGUNTAS ACERCA DE SUS EXPERIENCIAS EN SU CASA.

1. ¿En los últimos 6 MESES, usted llevó a cabo una posición elegida en su casa? SI____ NO____
Si respondio que si, qué posición
_____

¿Qué impacto tuvieron estas posiciones en su recuperación? (encierre en un circulo)
Muy Útil Útil Neutral No Útil Muy inútil

2. ¿En los últimos 6 MESES, a promedio cuanto tiempo usted ha dedicado en los queháceres de la casa por semana? ____

¿Qué impacto tuvieron los queháceres en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

3. ¿En los últimos 6 MESES, alguien en su casa le ha ayudado con el cuidado de sus niños? ____SI ____NO

¿Si respondio que si, qué impacto esto ha tenido en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

4. ¿En los últimos 6 MESES, usted ha participado en actividades sociales con otros residentes?
____SI ____NO

¿Si respondio que si, qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

5.¿En los últimos 6 MESES, usted ha hablado con otro residente sobre los problemas en su vida?
____SI ____NO

¿Si respondio que si, qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

6. En los últimos 6 MESES, ha recibido consejos de otros residentes de la casa sobre problemas personales? ____SI ____NO

¿Si respondio que si, qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

7. ¿En los últimos 6 MESES, usted ha hablado con otro residente sobre su adición o programa de recuperación?
____SI ____NO

¿Si respondio que si, qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

8. ¿En los últimos 6 MESES, usted ha recibido ayuda de otro residente de la casa para encontrar empleo?
____SI ____NO

¿Si es así qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

9. ¿En los últimos 6 MESES, usted ha recibido la ayuda de otros residentes de la casa para encontrar otros servicios en la comunidad? ____SI ____NO

¿Si es así qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

10. ¿En los últimos 6 MESES, los residentes le han ayudado con otras necesidades tales como transporte, diligencias, etc? ____SI ____NO

¿Si respondio que si, qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

11. ¿En los últimos 6 MESES, otros residentes le han dado consejos o sugerencias para la crianza de los hijos?
____SI ____NO

¿Si respondio que si, qué impacto ha tenido esto en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

12. ¿En los últimos 6 MESES, usted ha participad en reuniones individuales con otros residentes de la casa? ___SI ____NO

¿Si respondio que si, qué impacto han tenido estas reuniones en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

13. ¿En los últimos 6 MESES, usted ha recibido multas?
___SI ___NO

¿Si respondio que si, qué impacto han tenido estas multas en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

14. ¿En los últimos 6 MESES, los miembros de la casa lo han enfrentado por su comportamiento en la casa?
____SI ____NO

¿Si respondio que si, qué impacto han tenido estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

15. ¿En los últimos 6 MESES, usted ha recibido un "contrato" de los miembros de la casa?
____SI ____NO

¿Si respondio que si, qué impacto han tenido este contrato en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

16. ¿En los últimos 6 MESES, usted ha tenido la oportunidad de ayudar a otros miembros de la casa con un problema personal?
____SI ____NO

¿Si respondio que si, qué impacto tuvieron estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

17. ¿En los últimos 6 MESES, usted ha tenido la oportunidad de ayudar a otros miembros de la casa con su recuperación?
____SI ____NO

¿Si respondio que si, qué impacto tuvieron estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

18. ¿En los últimos 6 MESES, usted ha tenido la oportunidad de ayudar a otros miembros de la casa a encontrar un trabajo o servicios de comunidad? ____SI ____NO

¿Si respondio que si, qué impacto tuvieron estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

19. ¿En los últimos 6 MESES, usted ha tenido la oportunidad de ayudar a otros miembros de la casa con el cuidado de los niños?
____SI ____NO

¿Si respondio que si, qué impacto tuvieron estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

20. ¿En los últimos 6 MESES, usted ha asistido a una reunión de capítulo?
____SI ____NO

¿Si respondio que si, qué impacto tuvieron estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

21. ¿En los últimos 6 MESES, usted ha tenido posiciones del liderazgo en el Oxford House en el capítulo, al nivel estatuario o al nivel nacional? ____SI ____NO

¿Si respondio que si, qué impacto tuvieron estas experiencias en su recuperación?
Muy Útil Útil Neutral No Útil Muy inútil

AHORA, QUISIERA HACERLE ALGUNAS PREGUNTAS ACERCA DE RELACIONES EN LA CASA

1. Los miembros de la casa animan la comunicación en inglés o español, dependiendo del nivel de comodidad de los residentes (circule uno)

___ No estoy de acuerdo firmemente	___ No estoy de acuerdo	___ Neutral	___ Estoy de acuerdo	___ Estoy de acuerdo firmemente

2. Los residentes de la casa se tratan con dignidad y respeto

___ No estoy de acuerdo firmemente	___ No estoy de acuerdo	___ Neutral	___ Estoy de acuerdo	___ Estoy de acuerdo firmemente

3. Las relaciones entre residentes de la casa se valoran

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

4. Los miembros de la casa entienden la manera en que yo pienso

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

5. Los residentes se enfrentan de una manera respetosa

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

6. Los miembros de familia son animados a ayudar con la recuperación de los residentes'

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

7. Los miembros de la casa respetan mis valores y tradiciones culturales

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

8. Yo me siento conectado con los otros residentes

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

9. Me siento cómodo con los miembros de mi casa

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

10. Entiendo qué se espera de mí en la casa

___ No estoy de acuerdo firmemente **___ No estoy de acuerdo** **___ Neutral** **___ Estoy de acuerdo** **___ Estoy de acuerdo firmemente**

Cuáles son sus pensamientos sobre el tratamiento de sus valores culturales y creencias con la gente de Oxford House.

_____

_____