

Chapter 2

Promoting Disaster Recovery in Ethnic-Minority Individuals and Communities

Fran H. Norris and Margarita Alegría

People who identify as African American, Native American, Asian American, or Hispanic/Latino accounted for 30% of the U.S. population in 2000 and are projected to account for almost 40% of the population in 2025 (U.S. Department of Health and Human Services [DHHS], 2001). The mental health system in general and the disaster mental health system in particular are challenged to meet the needs of this increasingly diverse population. The issues are complex because the effects of ethnicity and culture are pervasive. They may influence the need for help, the availability of help, comfort in seeking help, and the appropriateness of that help. In this chapter, we review the evidence regarding each of these points to draw conclusions regarding how to promote disaster recovery in ethnic-minority individuals and communities.

NEED FOR MENTAL HEALTH SERVICES

Ethnicity and the Epidemiology of Mental Disorders

Consistent with the Surgeon General's Report, *Mental Health: Culture, Race, and Ethnicity* (DHHS, 2001), need is defined here as the prevalence of psychiatric disorder or elevated distress in the population. Prevalence rates are clearly imperfect measures of need, but they may serve reasonably as

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population-level markers of relative need for help. The inclusion of elevated levels of distress allows us to examine whether immigrants, particularly those who are less acculturated, are more likely to express their reactions to disaster by higher levels of distress, including cultural idioms, such as *ataque de nervios* or *neurasthenia*. Because research has pointed to posttraumatic stress disorder (PTSD) and depression as the two most likely adverse psychological consequences of disasters (Norris, Friedman, et al., 2002), we paid particular attention to the epidemiology of these two conditions. Findings from disaster research are best interpreted in light of the general epidemiology of mental disorders.

Holzer and Copeland (2000) presented a useful review of the role of ethnicity in the epidemiology of mental disorders in the United States and presented results from reanalyses of data from the Epidemiologic Catchment Area Survey (ECA) and the National Comorbidity Survey (NCS), two well-known national studies. In rank order, annual prevalence rates of major depressive disorder (MDD) were highest for Hispanics (4.0%, ECA; 14.1%, NCS), next highest for non-Hispanic whites (3.6%; 10.2%), somewhat lower but not very different for African Americans (3.2%; 8.4%), and lowest for Asian Americans (2.5%; 6.3%). More recent results of the National Comorbidity Survey Replication (NCS-R) indicate no ethnic differences in the rates of MDD between Hispanics and non-Hispanic whites (Kessler et al., 2003), but lower odds ratios for non-Hispanic blacks (odds ratio = 0.6, 95% confidence interval = 0.5–0.8). Perhaps because they composed the smallest subsample in the ECA and NCS, results were least consistent for Native Americans; their rate of MDD was lowest in the ECA (1.9%) but equivalent to that of African Americans in the NCS (8.5%).

These national surveys are supplemented by studies of particular or more localized populations. The Washington Needs Assessment Household Survey (WANAHS, also described by Holzer and Copeland, 2000) included over 1,000 Native Americans and, in this case, their MDD rate was the highest of all groups (11.7%, compared to 7.9% of white Americans). The Chinese American Psychiatric Epidemiology Study (CAPES; Takeuchi et al., 1998) replicated findings showing that Asian Americans had lower than average MDD prevalence rates. In the Mexican American Prevalence Study (MAPS; Vega et al., 1998), rates of MDD were comparable to those seen in the NCS but varied by place of birth, being higher for U.S.-born Mexican Americans than for Mexican-born participants. In general, researchers find that recent Latino and Asian immigrants tend to experience better physical and mental health outcomes than more established Latino and Asian residents (Takeuchi et al., 1998; Vega et al., 1998). Whether these outcomes can be attributed to selection processes or to acculturation into American lifestyles is open to conjecture. Overall, the available data on the need for mental health care suggest that prevalence rates of depression are similar or lower among ethnic minorities than among white Americans.

Estimating the relative vulnerability of culturally diverse groups to trauma is more challenging. The PTSD measure used in the ECA is generally considered to have been insensitive to the disorder regardless of ethnicity (e.g., Solomon & Canino, 1990). The NCS did not detect ethnic differences in the prevalence of PTSD (Kessler, Somnoga, Bromet, Hughes, & Nelson, 1995), nor did Norris (1992) in a survey of black and white residents of four midsize southeastern cities. CAPES found extraordinarily low rates of PTSD (1.1% of men and 2.2% of women reported by Norris, Foster, & Weisshaar, 2002, with the assistance and permission of CAPES investigators). MAPS, unfortunately, did not assess PTSD, but an epidemiological study of PTSD in Mexico (Norris, Murphy, Baker, Perilla, et al., 2003) found the lifetime prevalence of PTSD (11% after and 13% before the criterion of functional impairment was applied) to be substantially higher there than in the United States (8%). Using data from the National Vietnam Veterans Readjustment Survey (NVVRS), Ortega and Rosenheck (2000) found Puerto Rican and Mexican American veterans, but not other Hispanic veterans, to have higher probabilities of PTSD and more severe symptoms than non-Hispanic white veterans.

The Detroit Area Survey of Trauma (Breslau et al., 1998) showed African Americans to be at increased risk for PTSD relative to whites, but this effect dropped out when central city residence was controlled. Innercity Americans are disproportionately exposed to community violence (Osofsky, 1997; Parson, 1997). These findings suggest that more than minority status, living in urban inner cities with high exposure to community violence might pose increased risk for PTSD.

Limitations of the Epidemiological Research

Altogether, research on the epidemiology of depression and PTSD among American minorities is inadequate. The NCS Hispanic, Asian, and Native American samples were small in size, heterogeneous in terms of national origin, and limited to English-speaking persons. Supplementary surveys provided good data for specific subpopulations but can be generalized past them only with the utmost caution. The results quite obviously do not apply to the various smaller populations of Asian, African, Latino, and European refugees who live in the United States precisely because of violence and trauma in their home countries. Moreover, a number of investigators have argued that health data should be disaggregated by using subethnic groups (e.g., African Caribbean within the African Americans in the United States) because of considerable differences within groups (e.g., Srinivasan & Guillermo, 2000). For example, whereas Asian Americans as a group may appear similar to whites on a number of health-related and socioeconomic indicators, such statistics disguise higher rates of health problems and poverty among Asian American subgroups, such as the Vietnamese. These studies point to the complexity of understanding diverse subgroup process and the need to distinguish the impact of culture from minority status or poverty.

In addition to sampling, assessment raises a host of challenges. There is evidence to suggest that responses to screener items in diagnostic batteries may vary as a function of ethnicity/race, gender, education, and socioeconomic status of the respondent (Alegría & McGuire, 2003). A strict focus on traditional diagnoses may cause the clinician to miss “culture-bound syndromes” and somaticized distress (Kirmayer; 1996; Norris, Weisshaar, et al., 2001). Zheng and colleagues (1997) provided an excellent example of this in their research on *neurasthenia*, a condition that is recognized among Chinese Americans and is characterized by fatigue or weakness accompanied by an array of physical and psychological complaints, such as diffuse pains, gastrointestinal problems, memory loss, irritability, and sleep problems. Over half of those meeting criteria for neurasthenia did not meet criteria for any DSM-III-R (American Psychiatric Association, 1987) diagnoses. Another example is *ataques de nervios*. In a Puerto Rican disaster study, 14% of the sample reported experiencing these acute episodes of emotional upset and loss of control, although the rate of disaster specific PTSD was quite low (Guarnaccia, Canino, Rubio-Stipec, & Bravo, 1993). With these caveats, the available data appear to suggest that Latinos most consistently show elevated mental health needs and that black and white Americans do not consistently differ. Data for Asian and Native Americans are too sparse, contradictory, or both to draw any comparative conclusions.

Ethnicity, Culture, and Disaster Recovery

Despite a few exceptions, most disaster studies that have examined the effects of ethnicity on outcomes have found that minority ethnic groups fare worse than persons who are of majority group status (Bolton & Klenow, 1988; Galea et al., 2002; Garrison et al., 1995; Green et al., 1990; March, Amaya-Jackson, Terry, & Costanzo, 1997; Palinkas, Downs, Petterson, & Russell, 1993; Perilla, Norris, & Lavizzo, 2002; Webster, McDonald, Lewin, & Carr, 1995). A few noncomparative studies have similarly shown that postdisaster stress was quite high in particular ethnic communities (Chen, Chung, Chen, Fang, Chen, & Chen, 2003; Hough et al., 1990; Thiel de Bocanegra and Brickman, 2004). Ethnic differences in posttraumatic stress may point to effects of various risk factors, such as low socioeconomic status, chronic adversities, and differential exposure to the event itself that have little to do with culture per se. Nonetheless, culture can also shape the experience and consequences of disaster exposure.

Palinkas and colleagues' (1993) study of the aftermath of the *Exxon Valdez* spill is a case in point. The investigation revealed significant differences between Native Alaskans and others in rates of postdisaster major depression, generalized anxiety, and PTSD that were not explained by exposure alone. The spill interrupted subsistence activities, and these disruptions had greater impact on natives because they feared losing long-held traditions that defined their culture and community.

Perilla and colleagues (2002) explicitly tested whether *differential exposure* or *differential vulnerability* best explained their results showing that Latinos and non-Hispanic blacks were more adversely affected by Hurricane Andrew than were non-Hispanic whites. Consistent with the differential exposure hypothesis, non-Hispanic whites were less often personally traumatized and far less exposed to neighborhood-level trauma than the other groups. The severity of their exposure accounted for much of minority group members' higher posttraumatic stress. However, the interaction of trauma and ethnicity indicated that differential vulnerability also would have to be considered, and, in fact, some of minorities' disproportionate distress was explained by their higher levels of fatalism and acculturative stress. Fatalism refers to beliefs that fate plays a disproportionate role in life circumstances and that events are not under a person's control. Perilla and colleagues' findings are consistent with a large literature showing that external control is a risk factor for poor psychological outcomes following stressful life events (leading to increase vulnerability). It is reasonable to speculate that the intergroup tensions manifested in acculturative stress could exacerbate the effects of other stressors like job disruption or homelessness caused by a disaster. Theoretically, it was important to demonstrate that differential exposure and vulnerability can work in tandem and are not necessarily rival explanations.

Thiel de Bocanegra and Brickman's (2004) study was important for documenting the potential of disasters to affect the mental health of Asian Americans. In this sample of Chinese Americans seeking financial assistance after the September 11 terrorist attacks, 22% showed a pattern of symptoms consistent with PTSD, a rate strikingly higher than the presumed base rate of PTSD in this population. An additional study of Chinese Americans living in Chinatown, New York City, found that more than half of community residents reported one or more symptoms of psychological distress immediately following the event, but less than 4% received counseling from a mental health professional during the 5-month period after the disaster (Chen et al., 2003).

Also pertinent to this discussion are findings showing that culture shapes the effects of other important variables, such as gender and age, on postdisaster mental health outcomes. Norris, Perilla, Ibañez, and Murphy (2001) found that being of Mexican culture exacerbated gender differences and African American culture attenuated them. Webster and colleagues (1995) also found that sex differences in the effects of the Newcastle earthquake in Australia were greatest within the non-English-speaking immigrant portion of their sample. Norris, Kaniasty, Inman, Conrad, and Murphy (2002) examined age effects in three disaster-stricken samples. Among Americans, age had a curvilinear relation with PTSD such that middle-age respondents were most distressed. This was consistent with the other findings from the United States (Norris, Friedman, et al., 2002). Among Mexicans, however, age had a linear and negative relation with PTSD such that younger people were most distressed. Forming yet a third pattern, age had a linear and positive relation with PTSD in Poland, such that older people were most distressed after

the disaster. The authors interpreted the findings in light of anthropological research showing that the family life cycle is different in each of these societies. For our purposes here, the important lesson from this comparison is that there was no one consistent effect of disaster by age; rather, it depended on the cultural and historical context of the population and the country variance of social roles played at various ages (see also Chen et al., 2003).

USE OF MENTAL HEALTH SERVICES

Ethnic Disparities in Service Use

There are striking disparities for minorities in use of mental health services. To begin with, minorities in the United States are less likely than whites to seek mental health treatment until symptoms are more severe and less likely to seek treatment from mental health specialists, as they are more inclined to turn to primary care or to use informal sources of support (DHHS, 2001; Vega & Alegría, 2001). The disparities appear to hold specifically for PTSD as well as for mental disorders in general (Koenen, Goodwin, Struening, Hellman, & Guardino, 2003). There is substantial evidence that patients' views about health care differ by race, ethnicity, socioeconomic status, language, and literacy levels (Blendon et al., 1995; Carrasquillo, Ovar, Brennan, & Burstin, 1999).

Availability and Accessibility of Services

A number of explanations for these disparities have been offered, including insurance (Hargraves & Hadley, 2003) and inadequate detection of problems (Borowsky et al., 2000). The threshold for what is considered distressing or impairing may have strong cultural determinants, thereby producing an effect on reporting and ascertainment of symptoms that could have a bearing on diagnosis and detection. In many Hispanic and Asian cultures, communication in the absence of a relationship is not accepted or proper. Many immigrants have difficulties communicating in English or fear immigration or legal authorities, leading them to never receive care (Castaneda, 1994). Sue, Fujino, Hu, and Takeuchi (1991) concluded that an important cause of underutilization is the limited availability of culturally competent psychotherapists and culturally responsive services. Altogether, these facts point to a general problem in the availability and accessibility of mental health care for American minorities.

Help-Seeking Comfort, Stigma, and Mistrust

It is difficult to isolate *help seeking* from *help receiving* in most of the literature. It is often assumed that minorities possess more negative attitudes about

seeking help because of the findings showing that they receive less help than white Americans. However, the issue for minorities is not help seeking per se. Kaniasty and Norris (2000) studied ethnic differences in help-seeking comfort after Hurricane Andrew. All ethnic groups reported feeling most comfortable requesting help from family, somewhat less comfortable seeking help from friends, and the least comfortable seeking help from outsiders (which would include formal sources). Overall, minorities held more rather than less positive views about seeking help from other people, and this effect was more rather than less pronounced for outsiders. If these findings at first seem surprising, they actually are in accord with cross-cultural descriptions noting the greater value that white Americans place on self-reliance. Still, most people prefer receiving help from natural, informal sources.

Of course, the preceding results did not specifically address willingness to acknowledge a mental illness and to seek professional help for that problem. The Surgeon General's Report (SGR) (DHHS, 2001) identified stigma as a critical barrier to the use of mental health services. Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness. People with mental problems internalize public attitudes and conceal symptoms to avoid embarrassment or shame. Stigma is pervasive in American society and prevalent among white Americans as well as among minority groups.

Mistrust is a somewhat different issue than stigma. As reviewed in the SGR, African Americans and Latinos are more likely to feel that a health provider has judged them unfairly and to be afraid of mental health treatment. Allen (1996) argued that shame and guilt were especially common in African American PTSD patients who may be hypersensitive to outsiders, including therapists, if they seem to stand in harsh judgment of them. Minorities also appear to have greater concerns around side effects and addiction potential of medication (Cooper-Patrick et al., 1997). For these and other issues of trust, even when offered, minorities may be less likely to opt for receiving evidence-based treatments such as antidepressant medication or specialty psychiatric care (Miranda & Cooper, 2002; Wang, Bergland, & Kessler, 2000; Young, Klap, Shebourne, & Wells, 2001). More research is needed, but at present the data suggest that (1) stigma is a pervasive problem in America and (2) mistrust exacerbates its effects among minorities.

Promoting Service Use in the Aftermath of Disasters

The SGR noted that such negative attitudes could be addressed through public education efforts that are tailored to the languages, needs, and cultures of ethnic minorities. They proposed that one way to advance these efforts would be to involve representatives from the community in the design, planning, and implementation of services. On the basis of results from refugee programs, they concluded that successful programs do aggressive outreach and furnish a familiar and welcoming atmosphere (DHHS, 2001, p. 166). Disaster

mental health services begin with critical assumptions (Flynn, 1994; Norris et al., Chapter 18, this volume) that match these recommendations quite well. First, crisis counseling programs assume that disaster victims are normal people responding normally to abnormal situations and therefore that services should be directed at normalizing individuals' experience and distress. By normalizing distress and help seeking, disaster services afford atypical opportunities to destigmatize mental health care. Second, crisis counseling programs assume that people prefer natural sources of assistance and therefore that services should be provided in schools, churches, and places of work. Third, these programs assume that people who need help the most may not necessarily seek it and therefore that services must assume a proactive posture to reach out to vulnerable groups.

There are few data that document whether these principles actually help to reduce disparities in service use. However, some data from Project Liberty in New York provide tentative support for the hypothesis that minorities are as likely as others to seek and receive care when other barriers are reduced (stigma, mistrust) or eliminated (cost). The ethnic breakdown of crisis counseling recipients matched the demographics of New York quite well (Felton, 2002). Moreover, in a diverse sample of 800 adults receiving crisis counseling services, and with the intensity of psychological reactions controlled, African American and white clients were equally willing to accept a referral to "enhanced services" (treatment). Hispanic ethnicity actually increased the likelihood that the referral was accepted (Norris, Donahue, Felton, Watson, & Hamblen, 2004).

Although Project Liberty was generally successful in reaching out to minority communities in the aftermath of 9/11, there was room for improvement (Norris et al., Chapter 18, this volume). Sometimes trust was difficult to establish. Most often mentioned was the difficulty in engaging the Muslim community. Sometimes hostilities were encountered in communities that had a multitude of predisaster problems and histories of neglect (Battery Park and Harlem were mentioned as two good examples in New York) but were overcome by involving community members in generating strategies and solutions.

APPROPRIATENESS OF MENTAL HEALTH SERVICES

Shortcomings of the Evidence Base for Minorities

The challenge for serving American minorities is to be both scientifically and culturally appropriate. The SGR concluded that the evidence base regarding effective treatments for minorities has remained quite poor (DHHS, 2001). Although effective treatments are available for many mental disorders, they are not being translated into community settings and are not being provided to everyone who comes in for care. The gap between research and practice is

worse for minorities. The evidence base is meager but improving for trauma and PTSD. Zoellner, Feeny, Fitzgibbons, and Foa (1999) found no ethnic differences in completion rates and achieved equivalent results for 60 white and 35 black female assault victims who had been randomly assigned to active cognitive-behavioral treatment (CBT) or waitlist control. Kataoka and colleagues (2003) showed that an eight-session CBT intervention for Latino students exposed to community violence produced significant declines in depression and PTSD symptoms compared to a wait-list control. Many more studies like these are needed to establish the efficacy of various treatment approaches.

Ethnic Disparities in Quality of Care

A few studies have raised concerns about the overall quality of care being received by minority clients in community settings. Even after entering care, minorities face a higher risk of being misdiagnosed. This may be due to minorities being more likely to seek help in primary care as opposed to specialty care, where about one-third to one-half of patients with mental disorders remain undiagnosed (Williams et al., 1999). But even in psychiatric evaluation in emergency rooms, minorities are at greater risk of non-detection of mental disorders (e.g., Borowsky et al., 2000).

In many studies in the United States, members of minority groups are found to receive inferior health care compared to white patients. Using data from a large-scale survey, Wang and colleagues (2000) examined proportions receiving care that could be considered consistent with evidence-based treatment recommendations. This was defined operationally as attending at least four therapy sessions plus receiving medication or attending eight sessions in the absence of medication. African Americans were much less likely than white Americans to have received such care. Similarly, Young and colleagues (2001) showed that Latinos were less likely than non-Hispanic whites to receive treatment that was in accord with evidence-based guidelines.

Inappropriate prescription of medication is a source of significant concern. Clinicians in psychiatric emergency services prescribe both more and higher doses of oral and injectable antipsychotic medications to African Americans than to whites (Segel, Bola, & Watson, 1996), even when research recommends lower dosages to African Americans due to their slower metabolizing of some antidepressants and antipsychotic medications (Bradford & Kirlin, 1998). African Americans are less likely than whites to receive an antidepressant when their depression is first diagnosed and less likely to receive newer selective serotonin reuptake inhibitors (SSRIs), once medicated (Melfi, Croghan, Hanna, & Robinson, 2000).

Some studies suggest that retention and outcomes are superior when clients and clinicians are matched ethnically (Sue et al., 1991), but the crux of the matter may be *cognitive match*—that is, the congruence between therapist

and client conceptions (Sue, 1998). One central dimension of care is the physician's or clinician's ability to communicate with the patient. The diagnostic formulation and treatment of mental disorders rely to a large degree on verbal communication between patient and physician about symptoms, the understanding of the possible causes of the problem, and the proper assessment of its impact on functioning. Miscommunication can lead to misdiagnosis, mismatch between the patient and the provider's expectation about treatment, and poor adherence to treatment. The assessment process is thus especially important when treating non-English-speaking populations.

Frameworks for Cultural Competence

The adoption of cultural competence as an overriding principle of services for minority populations is based in the premise that caregiver's or agencies' understanding of a person's cultural background and experience facilitates a better match of services and thus more effective care and improved client outcomes. Siegel and colleagues (2000) provided a series of indicators that may serve to establish the performance of the agency or system in providing culturally competent services. Some of the indicators include consumer and family involvement in the design of services, training of staff in cultural competence, and number of services adapted for cultural or racial groups.

In recent years, various recommendations have appeared for creating culturally competent mental health services. Cultural competence refers to the behaviors, attitudes, skills, and policies that help mental health caregivers to work effectively and efficiently across cultures (New York State Office of Mental Health, 1997). Of these, the best known is the *Outline for Cultural Formulation* published in the appendix of DSM-IV (American Psychiatric Association, 1994). The process of applying DSM criteria across cultures involves several steps: (1) assessing the cultural identity of the client, including his or her degree of involvement with the culture of origin and host culture; (2) exploring cultural explanations for the individual's symptoms, including his or her perception of their cause; (3) exploring cultural factors related to the psychosocial environment and level of functioning, with particular attention to social stressors and social support and the role of religion and kin networks in the person's life; (4) identifying cultural elements in the relationship between the individual and clinician, such as differences between them in language and heritage; and (5) creating an overall formulation of diagnosis and care. The formulation has been criticized for not going far enough (e.g., Lopez & Guarnaccia, 2000), but it nonetheless represents a tremendous step forward for multicultural care.

Around the same time, the American Psychological Association (1993) established benchmarks for cultural competency. The competent provider is characterized by an awareness of his or her own assumptions and values, a respect for the worldviews of clients, and the ability to develop culturally

appropriate interventions. Knowledge, beliefs, and attitudes must all be considered. Yet, there is evidence suggesting that clinician bias and stereotyping play a role in medical decision making. For example, broadly adopted stereotypes of Asian Americans as “problem free” may lead providers to miss an individual’s mental health problems (Takeuchi & Uehara, 1996).

Fortunately, certain goals of psychotherapy can reasonably be assumed to be universal, such as the removal of distressing symptoms and communication of empathy (Draguns, 1996). Beyond these goals, standard practices are likely to need some adaptation across cultures. Vega (1992) summarized the challenges well by noting that “off-the-shelf” intervention materials are difficult to use in diverse settings because they are unknowingly embedded with cultural expectations and unsubstantiated assumptions about such issues as time orientation, social and occupational commitments, family structure, and gender roles. These issues are overlooked by interventionists with surprising regularity. Intervention materials, levels of respondent burden, and assessment protocols must be carefully reviewed by community judges before a program can be piloted and evaluated in the targeted community or population.

Sue (1998) advised that an important component is *scientific mindedness*, saying, “By scientific mindedness, I am referring to therapists who form hypotheses rather than make premature conclusions about the status of culturally different clients, who develop creative ways to test hypotheses, and who act on the basis of acquired data” (p. 445). Sue continued by noting:

A good clinician who is uncertain of the cultural meaning of a symptom should engage in hypothesis testing. For example, if the symptom is a reflection of a psychotic episode rather than a culturally influenced characteristic, one would expect (a) the client to manifest other psychotic symptoms, (b) other individuals in the culture to be unfamiliar with the symptom, or (c) experts in the culture to indicate that the symptom is unusual in that culture. (p. 446)

However, this type of assessment might be particularly difficult to implement in the absence of cultural psychiatric liaisons, such as the ones proposed by Kirmayer and Young (1999).

On the basis of many years of experience working with traumatized refugees, Kinzie (2001) advised cross-cultural treatment programs to incorporate several key elements. These elements appear to apply to postdisaster clinical settings quite well. Such programs need to be able to treat major disorders in addition to PTSD because of high rates of comorbidity (e.g., depression and substance abuse) in some populations. Programs must address language needs, and they must be easy to access and perceived as credible. In addition, according to Kinzie, the program must have linkages with other services, integrate care for both physical and mental disorders, create mechanisms for feedback and advice, and be staffed by competent clinicians and

bilingual mental health workers who can create bridges between the patient and professional staff.

Social Functioning as an Organizing Principle for Multicultural Interventions

Draguns (1996) speculated that cultural dimensions, especially individualism–collectivism, provided clues for the content of multicultural interventions. He reasoned that in individualist cultures that emphasize independence, it is appropriate for self-actualization to serve as the ultimate goal of psychological interventions, whereas in collectivistic cultures that emphasize interdependence, it would be more fitting to aim for the attainment of harmonious social relationships. Both objectives are inherently desirable; it is only their respective prominence that would differ given the cultural identity of the client. We agree with these points and would like to elaborate further on their implications for the content of multicultural postdisaster interventions. Individualist and collectivist cultures subsume strikingly different constructions of self (Markus & Kitayama, 1994). In collectivist cultures, such as found across most of Latin America and Asia, the self is unbounded and fundamentally interrelated with others. The goal is not to become autonomous but to fulfill and create obligation and, in general, to become part of various interpersonal relationships. In an important cross-cultural study, Kitayama, Markus, and Matsumoto (1995) distinguished between socially engaged emotions (e.g., feelings of closeness), socially disengaged emotions (e.g., pride), and generic emotions (e.g., happiness). They found that socially engaged emotions were more strongly related to emotional states than were socially disengaged emotions among the Japanese, whereas the reverse was true in the United States.

This finding is of particular interest for our purposes because perceptions of belonging and being cared for are critical to the well being of disaster victims (see Kaniasty & Norris, 2004, for a review of the literature on disasters and social support). Across a variety of settings both within and outside the United States, Kaniasty and Norris have shown that disasters exert their adverse impact on psychological distress both directly and indirectly, through disruptions of social relationships and expectations of support. This disruption of social supports occurs just when the need for them is at its highest. A disaster is an excellent example of a community event that alters the quantity and quality of social interactions. Because disasters affect entire indigenous networks, the need for support may simply exceed its availability, causing expectations of support to be violated. Relocation and job loss remove important others from victims' supportive environments. There are fewer opportunities for companionship and leisure. Physical fatigue, emotional irritability, and scarcity of resources augment the potential for interpersonal conflicts and social withdrawal. Interactions that are apparently supportive may be seen quite differently when one's obligations to help others in the

network are taken into account; reciprocity is highly valued in many cultures. Furthermore, it needs to be recognized that disaster recovery can be a long process. The heightened level of helping and concern evident initially cannot be expected to last for the full length of the recovery process. Nor are supportive resources distributed equitably. Following several disasters, it has been found that disaster victims who had fewer economic resources or were members of ethnic minority groups received less emotional support than did their comparably affected counterparts who had greater economic resources or were members of ethnic majority groups (Kaniasty & Norris, 1995). Socially and economically disadvantaged groups are frequently too overburdened to provide ample help to other members in time of additional need.

From this research, a clear and deceptively simple recommendation for culturally responsive postdisaster interventions can be drawn. This is always to remember that *the individual is embedded in a broader familial, interpersonal, and social context*. (See Hobfoll, 1998, for an exceptional elaboration on this point.) The interventionist or practitioner must spend time assessing—and addressing—socially relevant cognitions and emotions as well as the person's social supports, network demands, and performed and expected social roles. On the positive side are constructs such as (1) perceptions of social support, social competence, belonging, and trust; (2) mutuality and marital satisfaction; and (3) social participation, sense of community, and communal mastery. On the negative side are constructs such as (4) withdrawal, loneliness, isolation, interpersonal estrangement, shame, and remorse; (5) familial obligations, caretaking burdens, and parenting stress; (6) domestic and other interpersonal conflicts; and (7) hostility, anger, societal alienation, perceptions of neglect, and acculturative stress. Broadly speaking, *the intervention goal is to enhance social functioning*, which indirectly addresses an important risk factor for chronic PTSD (Norris, Murphy, Baker, & Perilla, 2003).

Some previous recommendations in the multicultural treatment literature are consistent with our own. As Lindsey & Cuéllar (2000) noted, "African Americans will respond more favorably if therapy efforts are directed toward the environment or toward working with the extended family or toward spiritualistic and/or religious interventions or toward strengthening interdependency" (p. 199). They went on to say that cognitive therapy provides a good example. Similar recommendations to adjust cognitive-behavioral interventions to make them acceptable to Latino culture have been offered by Vera, Vila, and Alegría (2003). The therapist's techniques are essentially the same regardless of culture, but the client's explanatory models are culturally derived.

Community Action

To be culturally responsive in the aftermath of disasters, practitioners need to go beyond providing traditional services in nontraditional settings and

embrace novel approaches to meeting community needs. Solomon (2003) summarized this well:

The major concern is in fostering natural resiliency. For many survivors, removing obstacles to self-help, or providing for basic needs such as food, shelter, education, and health care may be the only intervention needed. This type of secondary prevention may also involve reparations, provision of a safe and healthy recovery environment, and reunion of family and community members. The underlying goal is to empower victims to participate in their own recovery efforts so as to regain both a sense of control over their lives and an orientation toward the future. (p. 12)

Solomon went on to note, “Although professionals working in the mental health arena are seldom trained or prepared to work at a broader community level, the scale of these emergencies may require abandoning dyadic interventions for those that can be implemented via community action using a public health approach” (p. 12). Somasundaram, Norris, Asukai, and Murthy (2003) and Hobfoll (1998) similarly advocated for community-level interventions that foster community competence and ownership of problems and solutions. Culturally based rituals and traditions sometimes can be used as the basis for innovative interventions (Manson, 1997; Nader, Dubrow, & Stamm, 1999). No one set of recommendations will apply to all communities cross-culturally, and activities must be developed from the “bottom up” to match the cultural context and needs of the group. Working collectively toward specific, achievable goals is helpful for many communities; community gatherings also help people to interpret and share their experiences and to establish social links (Somasundaram et al., 2003).

The evidence base supporting the effectiveness of community-oriented trauma programs is minimal, and building such a base is crucial for the advancement of culturally competent care. A few pilot studies are promising. For example, Weine and colleagues (2003) described the “Tea and Families Education and Support” intervention for Kosovar refugees. Three months after entering the program, participants demonstrated increases in knowledge about trauma and mental health, use of mental health services, perceived social support, and family hardiness.

RECOMMENDATIONS

Table 2.1 summarizes the following recommendations:

- *Assess community needs early and often.* Prior research indicates that minorities are at elevated risk for postdisaster mental health problems such as depression and PTSD. Small but important percentages will have mental health needs that predate the disaster. Assessment of needs in disaster-stricken communities is critical, and these assessments should

Table 2.1. Guidelines for culturally sensitive postdisaster care

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- *Assess community needs early and often.* Gaps in rates of recovery, awareness of services, and use of services can be noted and addressed.
 - *Provide free and easily accessible services.* Minorities will be more likely to take advantage of services that are close to home, community-based, and offered in concert with other services and activities.
 - *Work collaboratively and proactively to build trust and to engage minorities in care.* To reduce disparities in service use, practitioners must get out of the clinic into the community.
 - *Validate and normalize distress.* Help seeking as well as symptoms can and should be normalized. Diagnosis of pathology should be deemphasized, relative to standard practice. An important task of the clinician is to help individuals identify and mobilize their natural resources.
 - *Value interdependence as well as independence as an appropriate goal.* The intervention goal is to enhance social functioning, helping the person retain or resume his or her social roles.
 - *Promote community action.* Novel and innovative strategies should be explored that involve minority communities in their own recovery by working toward specific, achievable goals.
 - *Recognize that cultural competence is a process not an end-state.* Continuing education is key.
 - *Advocate for, facilitate, or conduct treatment and evaluation research.* Researchers and practitioners should collaborate to test the efficacy and effectiveness of different intervention strategies for minority populations.
 - *Leave a legacy.* Disasters create opportunities to educate the public, destigmatize mental health problems, and build trust between providers and minority communities.
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oversample minority populations to determine the ways in which they were exposed and affected by the particular event. Because diagnoses may be less valid for minority persons and because they represent only the tip of the iceberg in any case, needs assessments should include a focus on experienced emotional distress and impaired functioning, especially social functioning. Valid needs assessments for culturally diverse populations also require information on contextual and cultural variables such as trauma exposure in the country of origin, losing of social ties, level of comfort in host society, and level of English-language proficiency. Gaining support among policy researchers is the notion of surveillance. Needs evolve. Repeating the needs assessment periodically will provide invaluable information about the extent to which minorities are recovering from the disaster, have recovered, or still require help. Gaps in rates of recovery, awareness of services, and use of services can be noted and addressed.

- *Provide free and easily accessible services.* Minorities often lack insurance and other means of paying for mental health services. They will be more likely to take advantage of services that are close to home, community-based, and offered in concert with other services and activities. This might translate in providing services in community-based organizations with sustainable relations with the minority community or offering services in schools or community facilities with easy access.

- *Work collaboratively and proactively to reduce stigma and mistrust and to engage minorities in care.* It should be anticipated at the outset that minority disaster victims, even those who have suffered intensely, will not necessarily seek professional mental health services, as they will tend to rely on families, friends, and other natural sources of help. Viewing this as an asset rather than a problem to be overcome reminds the interventionist to work collaboratively with natural helpers in the community, such as *promotoras* or paraprofessionals with experience and credibility in the community. To reduce disparities in service use, programs must build trust and be highly proactive; practitioners must get out of the clinic into the community. To the extent possible, programs should employ ethnic minority practitioners in the recruitment, retention in care, and recovery efforts. If such practitioners are scarce, they may serve the overall effort best in consultant, training, and supervisory roles. Local representatives of minority communities should be involved from the outset in preparing for and planning responses to disasters and terrorism.
- *Validate and normalize distress.* Over and over again, experienced disaster and trauma clinicians emphasize that some distress is a normal reaction to an abnormal event. But this does not mean that help cannot lessen that distress or hasten recovery. Help seeking as well as symptoms can and should be normalized. Diagnosis of pathology should be deemphasized, relative to standard practice. Even when highly stressed, most people possess strengths they can draw on, and an important task of the clinician is to help individuals identify and mobilize their natural resources. At the same time, education regarding when dependence solely on self-reliance can be harmful to overcoming one's mental health problems or emotional distress should also be a task of disaster service providers. Self-reliance ("can handle the problem on my own") is a strong barrier to mental health care (Ortega & Alegría, 2002).
- *Value interdependence as well as independence as an appropriate goal.* As noted previously, the individual is embedded in a broader familial, interpersonal, and social context. The practitioner must spend time assessing and addressing socially relevant cognitions and emotions. The intervention goal is to enhance social functioning, helping the person retain or resume his or her social roles.
- *Promote community action.* Novel and innovative strategies should be explored that involve minority communities in their own recovery by working toward specific, achievable goals. Social marketing, advocacy, community organizing, train-the-trainer models, and mentoring programs are but a few examples that can be explored. By assuming a consultant or facilitator role, practitioners can help communities make informed choices while still recognizing that the choices are the community's own. At the same time, finding out about successful community interventions with similar communities and populations

might help identify ingredients that can be used to enhance mainstream interventions.

- *Recognize that cultural competence is a process not an end-state.* Clinicians will only experience despair if they are expected to know everything that would be helpful about every culture that makes up the American whole. The importance of continuing education cannot be overstated.
- *Advocate for, facilitate, or conduct treatment and evaluation research.* There are still so few data on which to base recommendations for culturally responsive mental health care. Minorities will ultimately be better served if practitioners and researchers collaborate to test the efficacy and effectiveness of different intervention strategies.
- *Leave a legacy.* Notwithstanding the pain and stress they cause, disasters create opportunities to educate the public about trauma and mental health, to destigmatize mental health problems and mental health services, to build trust between service providers and minority communities, and to develop collaborative relationships that may serve the entire populace for years to come.

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