Mental Health Care for Ethnic Minority Individuals and Communities in the Aftermath of Disasters and Mass Violence

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FOCUS POINTS

- Research suggests that ethnic minorities (African American, Asian Americans, Native Americans, and Latinos) may suffer more adverse psychological consequences after disasters and mass violence than do white Americans.
- Ethnic disparities in the availability, accessibility, and quality of mental health care are well documented. However, there are many aspects of disaster mental health practice that may serve to reduce traditional barriers.
- Community-based mental health care that addresses socially engaged emotions and aims to assist victims with their social functioning may provide a good fit with the cultural perspectives and needs of many American minority groups.

ABSTRACT

Findings from research on psychiatric epidemiology, disaster effects, discrepancies in service use, and cross-cultural psychology are reviewed to generate guidelines for culturally responsive postdisaster interventions. Ethnicity and culture influence mental health care at various points: on need for help; on availability and accessibility of help; on help-seeking comfort (stigma, mistrust), and on the probability that help is provided appropriately. There are aspects of disaster mental health practice that may ameliorate many of barriers that contribute to ethnic disparities in service use. It is proposed that interventions should give greater attention to socially engaged emotions and functioning. To promote disaster recovery, practitioners are advised to: assess community needs early and often; provide easily accessible services; work collaboratively and proactively to reduce stigma and mistrust and engage minorities in care; validate and normalize distress and help-seeking; value interdependence as well as independence as an appropriate developmental goal; promote community action; and advocate for, facilitate, or conduct treatment and evaluation research. Notwithstanding the pain and stress they cause, disasters create opportunities to de-stigmatize mental health needs and build trust between providers and minority communities.

CNS Spectr. *2005;10(2):132-140*

INTRODUCTION: MENTAL HEALTH CARE FOR ETHNIC MINORITY INDIVIDUALS AND COMMUNITIES IN THE AFTERMATH OF DISASTERS AND MASS VIOLENCE

People who identify themselves as African American, Asian American, Hispanic/Latino, American Indian, Alaskan Native, or Native Hawaiian accounted for 30% of the United States population in 2000 and are projected to account for ~40% of the population in 2025.[1] 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 article, we briefly review the evidence regarding each of these points to draw conclusions regarding how to promote disaster recovery in ethnic minority individuals and communities.

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Disclosure: This article was supported by National Institute of Mental Health grant KO2 MH63909, awarded to Dr. Norris, and National Institute of Mental Health grant KO2 MH59878, awarded to Dr. Alegria. This article was submitted on January 30, 2004, and accepted on November 1, 2004.

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THE 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* (SGR),[1] need is defined here as the prevalence of psychiatric disorder or elevated levels of distress in the population. Prevalence rates are clearly imperfect measures of need, but they may serve reasonably as population-level markers of relative need for help. Because research has pointed to PTSD and depression as the two most likely adverse psychological consequences of disasters,[2] 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[3] presented a useful review of the role of ethnicity in the epidemiology of mental disorders in the United States and presented results from re-analyses 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 Hispanic adults (4.0% ECA, 14.1% NCS), next highest for non-Hispanic white adults (3.6%, 10.2%), somewhat lower but not very different for African American adults (3.2%, 8.4%), and lowest for Asian American adults (2.5%, 6.3%). More recent results of the National Comorbidity Survey Replication (NCS-R)[4] indicate no ethnic differences in the rates of MDD between Hispanic and non-Hispanic white adults, but lower odds ratios for non-Hispanic Black adults. 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. Holzer and Copeland[3] also described The Washington Needs Assessment Household Survey, which included >1,000 Native Americans/American Indians and, in this case, the MDD rate was the highest of all groups (11.7%, compared with 7.9% of white Americans). The Chinese American Psychiatric Epidemiology Study (CAPES)[5] replicated findings showing that Asian Americans had lower than average MDD prevalence rates. In the Mexican American Prevalence Study (MAPS),[6] overall rates of MDD were comparable with those seen in the NCS but varied by place of birth, being higher for US-born Mexican Americans than for Mexican-born participants. In general, researchers[5,6] have found that recent Latino and Asian immigrants tend to experience better physical and mental health outcomes than more established Latino and Asian residents. 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 suggests 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.[7] The NCS did not detect ethnic differences in the prevalence of PTSD;[8] nor did Norris[9] in a survey of black and white residents of four mid-sized southeastern cities. CAPES found extraordinarily low rates of PTSD (1.1% of men and 2.2% of women reported by Norris and colleagues[10]). MAPS, unfortunately, did not assess PTSD. However, an epidemiologic study of PTSD in Mexico,[11] found the lifetime prevalence of PTSD (11% after and 13% before the criterion of functional impairment was applied) to be substantially higher than in the US (8%). Using data from the National Vietnam Veterans Readjustment Survey, Ortega and Rosenheck[12] 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.

Ethnic differences in rates of lifetime PTSD have also been reported within Native American veteran samples.[13] Lifetime PTSD rates were 45% for Southwest Plains American Indians, 57% for Northern Plains American Indians, 38% for Native Hawaiians, 9% for Americans of Japanese ancestry, 34% for Hispanics, 35% for blacks, and 20% for whites. Nevertheless, it appears that ethnic differences are largely explained by degree of direct combat exposure.[14,15]

The Detroit Area Survey of Trauma[16] showed African Americans to be at increased risk for PTSD relative to white participants, but this effect disappeared when central city residence was controlled. Inner-city Americans are disproportionately exposed to community violence.[17] These findings suggest that more than minority status, populations living in inner cities with high exposure to community violence might pose increased risk for PTSD.

LIMITATIONS OF THE EPIDEMIOLOGIC 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 US due to violence and trauma in their home countries.

A number of investigators have argued that health data should be disaggregated by using subethnic groups (eg, Afro-Caribbean within the African Americans in the US) because of considerable differences within groups.[18] For example, whereas Asian Americans as a group may appear similar to white Americans 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 processes 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[19] 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. A strict focus on traditional diagnoses may cause the clinician to miss "culture-bound syndromes" and somaticized distress.[20] Zheng and colleagues[21] provided an 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 diagnoses. Another example is "ataques de nervios". In a Puerto Rican disaster study,[22] 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. 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[2,23,24] 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. A few non-comparative studies[25] have similarly shown that postdisaster distress was quite high in particular ethnic communities. Many studies showing[2,23,24,26] differences were conducted in the relatively acute postdisaster phase, and it is possible that the differences could dissipate over time. Moreover, ethnic differences in posttraumatic stress may be accounted for by 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.[27,28]

Palinkas and colleagues[29] studied 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[26] explicitly tested whether differential exposure or differential vulnerability best explained their results showing that Spanish-preferring Latino and non-Hispanic black victims were more adversely affected by Hurricane Andrew than non-Hispanic white victims. Consistent with the differential exposure hypothesis, non-Hispanic white victims 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. Theoretically, it was important to demonstrate that differential exposure and vulnerability can work in tandem and are not necessarily rival explanations.

Culture also shapes the effects of other important variables, such as gender and age, on postdisaster mental health.[30-32] For example, by using comparable methods and measures in both settings, Norris, and colleagues[31] tested whether cul-

ture interacted with gender in predicting outcomes after Hurricanes Andrew (in Miami; non-Hispanic sample only) and Paulina (in Acapulco, Mexico). Consistent with their predictions, Mexican culture exacerbated gender differences whereas African American culture attenuated them.

USE OF MENTAL HEALTH SERVICES

Ethnic Discrepancies in Service Use

There are striking discrepancies for minorities in use of mental health services. Minority groups are more likely than white Americans to delay seeking 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[1,33] The discrepancies appear to hold specifically for PTSD as well as for mental disorders in general.[34] The SGR concluded that minorities bear a greater burden than do white Americans from unmet mental health needs.

Availability and Accessibility of Services

A number of explanations for these discrepancies have been offered, including insurance[35] and inadequate detection.[36] Many immigrants have severe difficulties communicating in English and fear immigration or legal authorities, leading them to never receive care.[37] Sue and colleagues[38] concluded that an important cause of underutilization is the limited availability of culturally competent psychotherapists and culturally responsive services. Many African Americans, Native Americans, and Latinos live in rural areas that generally have limited mental health services.[1] 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 due to 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[39] 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. 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 SGR 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. Individuals 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[40] 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 over side effects and addiction potential of medication.[41] More research is needed, but at present the data suggest that stigma is a pervasive problem in America and that 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. On the basis of results from refugee programs, they concluded that successful programs do aggressive outreach and furnish a familiar and welcoming atmosphere. Disaster mental health services, in general, embrace a proactive posture. They make services more acceptable by avoiding psychopathology labels and more accessible by providing them in the heart of people's communities.[42,43] After September 11, 2001, many providers in New York worked evening and weekend hours, and a few were available "24/7." Despite their overall success in reaching out to minority communities, many providers believed there was room for improvement. Sometimes trust was difficult to establish. Sometimes hostilities were

encountered in communities that had a multitude of predisaster problems and histories of neglect but were overcome by involving community members in generating strategies and solutions.

Data from 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.[44] 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. (F.H. Norris, PhD, unpublished data, 2004)

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[1] concluded that the evidence base regarding effective treatments for minorities has remained quite poor. 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 SGR showed that the controlled clinical trials used to generate professional treatment guidelines did not conduct specific analyses for any minority group. The evidence base is meager, but improving, for trauma and PTSD. Zoellner and colleages[45] 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 therapy (CBT) or wait-list control. Kataoka and colleagues[46] showed that an eight-session CBT intervention for Latino students exposed to community violence produced significant declines in depression and PTSD symptoms compared with wait-list controls. Many more similar studies are needed to establish the efficacy of various treatment approaches.

Ethnic Discrepancies in Quality of Care

A few studies[1,36,47-49] 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.[36,47] They are less likely to receive care that is consistent with evidence-based treatment recommendation.[47,48] Inappropriate prescription of medication is a source of significant concern.[50,51]

Some studies suggest that retention and outcomes are superior when clients and clinicians are matched ethnically,[38] but the crux of the matter may be cognitive match (ie, the congruence between therapist and client conceptions).[52] According to Sue,[52] cognitive match refers to similarity of "explanatory models for clients' problems in terms of etiology, symptom meaning, course, and appropriate treatment." Miscommunication can lead to misdiagnosis, mismatch between the patient and the provider's expectation about treatment, and poor adherence to treatment.

Frameworks for Cultural Competence

In recent years, various recommendations[53-55] have appeared for creating culturally competent mental health services. Fortunately, certain goals of mental health services can reasonably be assumed to be universal, such as the removal of distressing symptoms and communication of empathy.[56] Beyond these goals, standard practices are likely to need some adaptation across cultures. Vega[57] summarized the challenges 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, assessment protocols, and self-monitoring materials must be carefully reviewed by community judges before a program can be piloted and evaluated in the targeted community or population.

On the basis of many years of experience working with traumatized refugees, Kinzie[58] advised cross-cultural treatment programs to incorporate several key elements. Programs must address co-morbidities, be easy to access and perceived as credible, have linkages with other services, integrate care for both physical and mental disorders, create mechanisms for feedback and advice, and be staffed by competent, bilingual mental health workers who can create bridges between the patient and professional staff.

SOCIAL FUNCTIONING AS AN ORGANIZING PRINCIPLE FOR MULTICULTURAL INTERVENTIONS

Draguns[56] 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. In an important cross-cultural study, Kitayama and colleagues[59] found that socially engaged emotions (eg, feelings of closeness) were more strongly related to generic emotions (eg, happiness) than were socially disengaged emotions (eg, pride) among the Japanese, whereas the reverse was true in the US.

This finding is of particular interest to the authors because perceptions of belonging and being cared for are critical to the well-being of disaster victims (see Kaniasty and Norris for review of the literature on disasters and social support[60]). Across a variety of settings both within and outside of the US, Kaniasty and Norris[60] 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. 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. Disaster victims who have fewer economic resources or are members of ethnic minority groups often receive less social support than their comparably affected counterparts. 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 post disaster interventions can be drawn. This is always to remember that the individual is embedded in a broader familial, interpersonal, and social context. (See Hobfoll[61] for an elaboration on this point.) The interventionist or practitioner must spend time assessing—and addressing—socially relevant cognitions, emotions, and roles. This includes constructs such as perceptions of social support, social competence, belonging, and trust; mutuality and marital satisfaction; social participation, sense of community, and communal mastery; withdrawal, loneliness, isolation, interpersonal estrangement, shame, and remorse; familial obligations, caretaking burdens, and parenting stress; domestic and other interpersonal conflicts; and hostility, anger, societal alienation, perceptions of neglect, and acculturative stress. Broadly, the intervention goal is to enhance social functioning, which indirectly addresses an important risk factor for chronic PTSD.[62] We do not mean to imply that self-efficacy is unimportant, simply that it should not be emphasized to the exclusion of interdependence. Some previous recommendations in the multicultural treatment literature are consistent with our own. For example, Lindsey and Cuéllar noted,[63] "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."

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.[53] Solomon[64] summarized this well: "Although professionals working in the mental health arena are seldom trained or prepared to work at a broader community level, the scale of these emergences may require abandoning dyadic interventions for those that can be implemented via community action using a public health approach." Somasundarum and colleagues[65] 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.[55,66] 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.[67] The best way to assure this is to involve the community in evaluating its own needs and strengths.

RECOMMENDATIONS

Due to the nascent state of the science our recommendations are not based solely upon empirical research but on a combination of existing research and prior commentaries. These recommendations span clinical, community, and social policy considerations.

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 assess-

ments should over-sample 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. 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. Although quantitative assessments are essential for estimating the extent and distribution of services that should be offered, they should be supplemented by qualitative assessments that identify culturally and ethnically specific outcomes and concerns of the population. Such data will inform the interventionist about the necessary content of the program, quite apart from the extent of the program.

Provide Low-Cost 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. Services provided by federally funded crisis counseling programs are free of charge. After major disasters, it might be advisable to sustain these programs for longer periods to allow underserved populations to take advantage of them.

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 as a problem to be overcome, reminds the interventionist to work collaboratively with natural helpers in the community. 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 de-emphasized, relative to standard practice. Even when highly stressed, most people possess strengths they can draw upon, and an important task of the clinician is to help individuals identify and mobilize their natural resources. Often the goal of normalizing distress is performed well by peers, role models, and paraprofessionals.[43]

Value Interdependence as well as Independence as an Appropriate Goal

As discussed previously, the individual is embedded in a broader familial, interpersonal, and social context. The interventionist or 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. Learning 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 and openness to change 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.

CONCLUSION

Notwithstanding the pain and stress they cause, disasters create opportunities to educate the public about trauma and mental health, to de-stigmatize 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. CNS

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Matthew Maingay, PhD(student), Marina Romero-Ramos, PhD, and Deniz Kirik, MD, PhD

Psychostimulant-Induced Behavior as an Animal Model of OCD

David Eilam, PhD, and Henry Szechtman, PhD