Guidelines for Providing Culturally Appropriate Services for People of African Ancestry Exposed to the Trauma of Hurricane Katrina

Association of Black Psychologists

In spite of the long and continuous history of a special brand of racial acculturation which for African American people took the form of human negation, nullification, cultural denigration, racist discrimination and socio-political disenfranchisement, African American people remain overwhelmingly a particular psycho-cultural community with ancestral rights and spiritual connections to each other and other people of African ancestry. Our common history of oppression and cultural retentions, as well as, shared experiences, philosophical outlook, collective memory, cultural legacy and mimetic heritage has resulted in a unique psychological complex which requires very specific technical expertise and understanding. Accordingly, any educational, socialization, habilitation and/or rehabilitation efforts designed for the African American survivors and victims of the Gulf coast tragedy will require high levels of specialized expertise and knowledge.

The destruction caused by Hurricane Katrina is virtually incalculable in terms of lives lost, families splintered, and economic costs. Never in this nation's history has a natural disaster so dramatically devastated the lives of so many African Americans. The massive displacement, homelessness, and overall trauma caused by the hurricane combined with the initial disorganization of the government's response will require on-going mental health services.

For African Americans experiencing this disaster it is important to take into consideration the personality of our social, economic, ethnic and cultural life. In other words, the shattering or unraveling of the various integrally joined systems of relationships must be managed as best as possible to decrease confusion while helping to provide a healthy sense of being and ultimately a sense of physical, emotional and spiritual balance. This includes but is not limited to social, political, educational, economic, religious and familial influences that make up the psycho-cultural complex of African American people.

In providing services to the African American survivors, providers of mental health services should be aware of the psycho-cultural issues related to traumatization and the universally appropriate responses to traumatic stress and strategies for helping the survivors cope. Providers of services should especially be aware of the culturally specific issues salient for the African American survivors and their experience.

Issues Relative to Trauma with African American People

While it is true that there are universal responses to traumatic stress, the events surrounding the hurricane and relief efforts require emic, or culturally responsive, interventions for the disproportionate number of African American citizens directly impacted by the hurricane. The Association of Black Psychologists are in a unique position to provide culturally responsive services for the victims of Hurricane Katrina. The provision of culturally sensitive and appropriate professional and licensed services to the thousands of displaced and traumatized African Americans requires more than good intentions and search, rescue and relocation activities. The following are a set of minimal guidelines that should inform both local and national efforts at providing mental health and social services for the African American survivors of Hurricane Katrina.

Therapist Preference

For many years the psychological literature has devoted a significant amount of attention to whether a client's preference for a particular therapist or mental service provider was influenced by the race or ethnicity of the therapist. While, several studies have indicated that Black clients prefer African American therapists or service providers over White therapists or service providers (Pinchot, Riccio, & Peters, 1975; Ponterotto, Anderson, & Grieger, 1986; Riccio & Barnes; Thompson & Cimbolic, 1978), without question, in times of crises and tragedy cultural and racial affinity are critical comforters and essential requirements for successful intervention and rehabilitation. It is important to acknowledge that for many economically disadvantaged African Americans, who may have limited or no experience with mental health service providers, a necessary condition for successful therapeutic outcomes is the trust found with African American service providers.

The Association of Black Psychologists understands that the relief efforts for the victims of Hurricane Katrina should, must, include significant numbers of African American mental health service providers.

Cultural Mistrust

Mental health service providers should also be aware that because of the history of racism and White supremacy in this country, many African Americans experience a mistrust of perceived White institutions (e.g., police, education, work, politics, law, mental health agencies) FEMA and the Red Cross are not exempt from this historically conditioned suspicion and mistrust. There are racial differences in medical care , with African Americans being more likely to receive differential and most often inadequate medical care than Whites which contributes to an ever deepening distrust (Brandon, Isaac, & Laveist, 2005). Many African Americans, in fact, prematurely terminate counseling because of cultural mistrust (Terrell and Terrell,1984). Whaley's (2001) empirical review suggests that the mistrust African Americans have of majority White institutions applies to the therapy context as well.

The Association of Black Psychologists understands that FEMA, the Red Cross and all other helping agencies must recognize and insure that all providers of service to the African American victims of Hurricane Katrina be sensitive to and non-defensive of the reality of historically conditioned mistrust.

Racial Identity Attitudes

Surprisingly, the most important predictor of therapist preferences for African Americans is not the race or ethnicity of the therapist, but rather, is the racial identity attitudes of the clients (Parham & Helms, 1981, 1985; Helms & Carter, 1991). African Americans with a strong African American identity prefer African American mental health service providers (Jackson & Kirschner, 1973). Thus, instead of simply matching Black clients with Black therapists, an assessment of the racial identity attitudes of both client and therapist is believed to be a better predictor of therapist preference.

The Association of Black Psychologists understands that there will be many African American victims of Hurricane Katrina who will prefer and require African American service providers.

African-centered (Optimal) Worldview

It should be obvious that people of African ancestry share certain orientations based on similar cultural experiences (Karenga, 2003, Asante, ____, Nobles,_____). The shared orientations include, but are not limited to, 1) centrality of community, 2) a high level of spirituality and ethical concern, 3) harmony with nature, 4) believing in the interrelatedness and interconnectedness of all things in the universe. This shared cultural orientation is also reflected in the psychology of the people (Akbar, ___, Nobles,_____, Kambon,_____, Washington_____, Myers, 2003). One important thing to note is that in an Afrocentric or optimal worldview, there is no clear distinction between the spiritual and material (Myers, 1988) and that a suboptimal worldview equates self-worth with what one owns, how one looks, what kind of car one drives, and what kind of house one has (Myers, 1988). Emphasis on commodities and possessions in the context of discrimination and disenfranchisement exacerbates the importance of having "things." A suboptimal orientation is the product of living in a Eurocentric society that values materialism and possessions over interpersonal relationships with people (Myers, 1988).

The Association of Black Psychologists understands that when providing mental health services to the African American survivors of Hurricane Katrina, it is important to let the survivors grieve the loss of property and possessions; however, it is equally, if not more important, to help the survivors reframe the meaning of the loss of material possessions in the context of survival and the resiliency of the human spirit.

Religiosity and Spirituality as Sources of Coping

Black religious expression, similar to other religious traditions, has addressed the existential meaning of personal suffering and death (Taylor, Chatters, and Levin, 2004). Religion can be defined as an organized system of beliefs, practices, and rituals designed to facilitate closeness to God (Koenig, McCullough, and Larson (2001). The National Survey of Black Americans (NSBA) found that the majority of respondents (82.2%) believe that the church helped the condition of Blacks in America (Taylor et al., 1987), and that more positive assessments of the church's sociohistorical role can be found by individuals living in the South (Taylor et al., 1987). Prayer is one of the most important religious behaviors, and serves as a source of coping with personal tragedy or adverse personal circumstances for many African Americans (Taylor, Chatters, and Levin, 2004). African Americans had a significantly higher belief in the curative power of prayer than other ethnic groups (Klonoff & Landrine, 1996). Blacks pray more frequently than Whites (Taylor, Chatters, Jayakody, & Levin, 1996). African Americans frequently asked others to pray on their behalf and frequently pray as a form of religious coping. Black women were more likely to use prayer than Black men when coping with problems. Prayer helps individuals to commune with God and to endure the stressors of life. (cf. Ellison and Taylor, 1996)

Ministers and other clergy have historically held a high status in African American communities and are critical "Ist Responders" for the African American community. Research suggests that some African Americans may rely on clergy to address mental health problems (Neighbors, Musick, & Wiliams, 1998). Additionally, clergy often have an advantage over mental health service providers because they do not charge for services (Taylor, Chatters, and Levin, 2004).

The Association of Black Psychologists understands that culturally responsive services for the African American survivors of Hurricane Katrina require an acknowledgement and use of the individuals' level of religiosity. In some cases this may mean using prayer as a tool or intervention, among others, to help individuals cope with the gravity of their situations. This means utilizing the religious and spiritual guidance of ministers or other clergy in conjunction with professional Black Mental health service providers as a part of a long-term treatment plan for the hurricane survivors. Additionally, it is inappropriate to expect the poor and displaced survivors of the hurricane to pay for mental health services. All mental health services provided for the survivors should be part of the government sponsored recovery plan and support and/or be pro bono, for an extended period of time.

Spirituality can be defined as a personal search for understanding the answers to existential questions about life, meaning, and relationships to the sacred (Koenig, McCullough, and Larson, 2001). African Americans have been more likely to identify as being both spiritual and religious, versus being only spiritual or religious, or neither (Taylor, Chatters Jayakody, & Levin, 1996). Belief in a divine

force that intervenes in one's life is consistent with an African cultural worldview (Grills, 2002). Many African Americans who are religious and/or spiritual will struggle with understanding why this tragedy occurred. There will most likely be some instances of intense anger directed toward God.

The Association of Black Psychologists understands that culturally responsive services for the African American survivors of Hurricane Katrina should empower the client by creating spaces that allow the expression of anger, and that also cultivate attitudes and coping behaviors that are consistent with indigenous beliefs and customs (eg. African centered, optimal worldview. Additionally, mental health service providers should strive to discourage negative or victim-blaming attributions by the survivors and the saviors.

Communication Style

One of the biggest barriers to the provision of culturally competent services is cross-cultural differences in communication. The combination of socio-economic status, education, and culture all impact how individuals communicate. However, the unrecognized retention of African linquistic rule structures of English speaking African Americans (eg., Ebonics) further complicates the issue of communication in helping. It, therefore, becomes critically important for therapists and mental health service providers to be able to understand the nuances of Black language use (Sue and Sue, 2003). Social and cultural distance, as well as attitudes of indifference and/or superiority are, in part, reflected in and the results of attitudes about language. Attitudes about language and the people who speak a particular way, can inhibit mental health providers' ability to engage with African American clients. Different communication styles are also likely to result in differences in the expression of symptoms (e.g., Neal-Barnett & Smith, 1997; Whaley, 1997).

The Association of Black Psychologists understands that because a disproportionate number of poor African American survivors in New Orleans and the Gulf region speak Ebonics, cultural and language barriers will represent a real and critical challenge for White service providers or any other service providers who are not familiar with and respect African American language. Being able to effectively communicate is an important prerequisite for rapport building. The ability of mental health service providers to provide culturally responsive services may be greatly impacted by the ability to communicate in a culturally effective manner.

African American communication has been described as high-context, where Blacks rely on less words and more non-verbal messages than what is actually spoken (Jenkins, 1982, Weber, 1985). Additionally, traditional psychotherapy relies on "talk therapy" where the individual is expected to talk about his or her feelings and to develop insight into how s/he is feeling.

The Association of Black Psychologists understands that while talk therapy is important, it may be the case that a strict adherence to talk therapy for African Americans, especially those who are economically disadvantaged and traumatized , is inappropriate or ineffectual, especially considering that for older and more traditional African Americans talk therapy with a stranger has not typically been embraced. Flexibility regarding the manner in which help is administered is needed. The power of touching (e.g., hug of reassurance, caring) should not be underestimated for its healing powers.

Sociopolitical Considerations

Mental health practice has traditionally been a White, middle class activity that values rugged individualism, individual responsibility, and autonomy (Atkinson et al., 1998). Many problems encountered by African American clients reside externally to them (e.g., bias, discrimination, prejudice, etc.) and African Americans should not be faulted (Sue and Sue, 2003). There have been instances in the media when politicians, pundits and news anchors have criticized the predominantly poor African American citizens for not leaving the area, or for reckless looting. To blame the African American residents of New Orleans and the Gulf areas for not leaving their homes or for taking food, water, or even non-essential items to sell to use as payment to get their families transported out of harm's way is nothing more than victim-blaming (Ridley, 1995), and should be avoided at all costs. Not only is this victim-blaming, but it goes against the tenets and ethical principles of the Association of Black Psychologists (1983).

Traditional mental health approaches discourage giving advice or suggestions because of the fear of becoming too emotionally involved or losing objectivity. The provision of African-centered mental health services views emotional distance between the mental health service provider and client as undesirable and unproductive because it prevents the development of an authentic helping relationship (Schiele, 2003).

The Association of Black Psychologists understands that when working with the African American victims of Hurricane Katrina, emotional vulnerability may be acceptable, if not necessary, to connect with the victims on a basic human level. The African American survivors of Hurricane Katrina need to see not only the humane, but experience the human, side of the mental health service providers, because it is this realness and authenticity that resonates with the cultural orientation of people of African ancestry. This means that mental health service providers should allow themselves a full range of emotional and therapeutic expression, including being open enough to permit tears or expressions of grief, outrage, etc. in response to what the survivors have experienced.

Discussion of Racial Issues

The history of African Americans has been marked with both oppression and the struggle for freedom and dignity. More than any other population group in this country, African Americans have had to overcome institutionalized racism and racial oppression. Increased experiences with racial discrimination and stressful events have been found to be positively associated with psychiatric symptoms for African Americans (Klonoff, Landrine, & Ullman, 1999), general psychological distress (Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003; Moradi & Subich, 2003), and health-compromising behaviors such as cigarette smoking (Landrine & Klonoff, 1996). The effects of institutionalized racism on the mental and physical health of African Americans are widespread (Wicker & Brodie, 2004).

The Association of Black Psychologists understands that in keeping with the themes of realness and authenticity, mental health practitioners providing services to the African American survivors of Hurricane Katrina must be willing to honestly discuss the roles of institutionalized racism (and classism) in the woefully inadequate response of the federal and state governments. The African American survivors need an outlet to vent their frustrations with governmental beauracracy that was appallingly slow in responding to a crisis situation involving a predominantly poor and Black population. In addition, perceptions of racism surrounding these events may engender additional levels of psychological distress or psychiatric symptoms on top of those due to the trauma of the hurricane. Survivors may also be more vulnerable to using tobacco and alcohol as painkilling measures.

Key African American Mental Health Professional Organizations

Keep in mind that for some survivors/victims, a number of longstanding issues including poverty, racism, objectification, and marginalization have contributed to the additional stressors brought on by the natural disaster and the slow rescue efforts that followed. Therefore, organizations like The Association of Black Psychologists, the National Medical Association, The National Association of Black Social Workers can be contacted to secure additional information on mental health resources. Listed below are their respective WEB sites that may also provide helpful information on medical, psychological and social work resources positively supporting mental health. These sites are:

www.abpsi.org
www.nmanet.org
www.nabsw.org

Universal Responses

There are certain well-documented responses to traumatic events that human beings experience. This universal, or etic approach, is exemplified by work produced by *The American Academy of Experts in Traumatic Stress*, which has outlined the following as universal responses to traumatic events:

Emotional Responses: The individual may experience shock, where the individual feels highly anxious, stunned, and emotionally-numb. The individual may also feel intense feelings of panic, fear, hopelessness, helplessness, uncertainty, loss of sense of security, anger, hostility, irritability, depression, grief, and feelings of guilt.

Cognitive Responses: The individual may experience impaired concentration, confusion, self-blame, blaming others, and disorientation. The individual may experience flashbacks and perseverate, or constantly think about, the traumatic event.

Behavioral Responses: The individual may experience exhaustion, loss of appetite, nightmares, sleeplessness, and an inability to sit still. Individuals may engage in impulsive behaviors, seemingly aimless walking and pacing, and anti-social behaviors such as fighting, stealing, and temper tantrums.

Physiological Responses: The individual may experience chest pains, heart palpitations and rapid heart beat, difficulty breathing, elevated blood pressure, fatigue, fainting, dizziness, increased sweating, headaches, and upset stomach.

Related to these universal responses, providers of mental health services should be equipped to carry out the following protocol, referred to as *Acute Traumatic Stress Management (ATSM)*:

1. Observe and identify. Observe and identify the aforementioned responses to the traumatic event.
2. Connect with the Individual. This can include anything from a simple “How are you doing?” to the use of non-verbal communication (e.g., a gentle touch). The mental health service provider should be prepared to deal with intense displays of emotion (e.g., uncontrollable crying, screaming, panic, fear, anger, etc.).
3. Ground the Individual. Acknowledge traumatic event at a factual level. Address the event at a cognitive level. Focus on the here-and-now. Remember that the individual’s coping and problem-solving abilities may be impaired or overwhelmed.
4. Provide Support. Strive to give back a sense of control that has been taken from the individual. Do not talk a person out of a feeling. Children may need to be held and reassured that they are safe. Children may need outlets (e.g., drawing or coloring) to express their feelings.

5. Normalize the Response. Validating and normalizing an individual's experience will help the individual to know that s/he is a normal person trying to deal with an abnormal event. Do not over-identify with the individual or situation (e.g., "I know what it feels like…When I was…". It is important to communicate that the individual is experiencing normal responses to an abnormal event.
6. Prepare for the Future. Avoid saying phrases like "Everything is going to work out." These types of statements may serve to minimize an individual's feelings and cause the individual to feel misunderstood.

Strategies for Helping People Cope

The combination of property damage, unsanitary conditions, and the lack of public utilities is projected to delay the return of many residents for a protracted period of time. The long-term impact of this crisis on the personal, interpersonal and cultural identity of its residents has been traumatic. Mental health professionals and agencies need to help people find identifiable ways to effectively cope with the aftermath of unprecedented loss. However, given the predictable symptoms of disaster (i.e., anxiety, depression and PTSD), it is imperative that easy to understand physical and mental health strategies are in place to help people directly and indirectly affected by this crisis learn how to cope with or seek mental health services to help them manage the problems resulting from this event.

Stress, depression, and post traumatic stress may be the most identifiable results from this natural disaster. However, before a judgment or diagnosis can be made it is important to be aware of any history of past disaster or traumatic experience as well as mental illness or emotional disorders/problems that may have been aggravated by this event. It is not uncommon that younger and older people may have more emotional problems following a natural disaster. For more information concerning the reaction by age groups see the following web site link: ***Crisis Counseling Guide to Children and Families in Disasters, published by New York State Office of Mental Health.***
http://www.omh.state.ny.us/omhweb/crisis/crisiscounselingguide.pdf

Diagnoses associated with Trauma (*terms come from the DSM-IV-TR)*

1. Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror
B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
   (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
   (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
   (3) derealization
   (4) depersonalization
   (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, and people).
E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug or abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

2. Post Traumatic Stress Disorder

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning

about unexpected or violent death serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior), (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

3. Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: *Do not include symptoms that are clearly due to a general medication condition, or mood-incongruent delusions or hallucinations.*

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) Significant weight loss when not dieting or weight gain (e.g., a change or more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) Fatigue or loss of energy nearly every day

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode

C. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Additional sites for tips of what to look for can be found at the following links:
1. George Mason University Counseling Center's Link on Dealing with Disasters…
http://www.gmu.edu/departments/csdc/disaster.htm
2. Victims of Disasters: Helping People Recover-From Acute Distress to healing and Integration by Erwin Randolph Parson, Ph.D.
http://www.giftfromwithin.org/pdf/victims.pdf
3. Natural Disasters, Crisis Intervention and School Psychology: Melding Human Neds and Professional Roles by Ted Feinberg
http://www.nasponline.org/NEAT/MidwestFloods.pdf

Listed below are some additional web links that can provide additional information and resources designed to help readers better understand the effects of trauma and to establish strategies that can help improve resilience.

A Guide for African American Parents Link:
http://www.nichd.nih.gov/publications/pubs/crisis/helping_children_crisis.htm

Disaster handout and links:
http://www.trauma-pages.com/pg5.htm

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