Disaster Response to Communities of Color: Cultural Responsive Intervention

Prepared by:
Robert T. Carter, Ph.D.
Teachers College, Columbia University

For:

Connecticut Department of Mental Health and Addiction (DMHAS)
Connecticut Department of Children and Families (DCF)
University of Connecticut Health Center – Center for Trauma Response, Recovery and Preparedness (CTRP)
and the
Yale University School of Medicine

February 18, 2004

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Executive Summary

The training associated with responding to communities of Color must be grounded in the worldview and cultural patterns of that community.

Recommendations:

(1) Prior to another disaster DMHAS and CTRP should work with the various communities of Color and first responders such as the Police and Fire departments on intervention strategies and expectations.

(2) The pre-disaster preparedness plan should include training for crisis-personnel that has a strong focus on self-exploration of the responder. The self-exploration would be geared to building awareness of ones' own culture to facilitate interaction across race/ethnicity and culture.

(3) Deploy as soon as possible in responding to a disaster racially-culturally diverse response teams, especially in communities of Color.

(4) Training of crisis response teams should emphasize that within the targeted groups, such as children, elderly, healthcare workers, first responders, and underserved cultural groups, there will be racial-cultural variation.

(5) Disaster response would be enhanced if there were pre-disaster interaction between responders and members of the various communities of Color. The involvement might be focused on other community needs and concerns. The interaction would be designed to build relationships and mutual knowledge between the sets of culturally different people that will need to trust one another during a crisis.

(6) The needs assessment data collection process might use broader culturally based categories for data collection. For instance, data collection should include the use of race, ethnicity, and preferred language, and so on. The more specific data could inform the response teams about the characteristics of various communities of Color.

(7) The training of health care providers should include consideration, not only of the effects of first time traumatic effects, but also effects of prior traumatic experiences including experiences that are due to daily living (e.g. sudden death, car accidents, violence, and discrimination).

(8) There is strong reliance on traditional and mainstream theories and models for understanding human behavior in the training of crisis responders. There is valuable information in the traditional and mainstream literature, at the same time, many theories, models and techniques are culture bound and assume a European-American culture framework, one that may not transfer easily to members of communities of Color.

(9) Training of crisis response teams would be enhanced if group specific information regarding communities of Color were taught. For instance, when specific ethnic and racial groups are discussed the groups that reside in the area under consideration (in the State) should be presented.

(10) Research studies suggest that members of racial-cultural groups may express symptoms of distress in unique or culturally bound ways.

(11) Training of behavioral health providers should include representations of culture that are elaborate and complex. It would be necessary to avoid the dynamic cultural conflict inherent in American cultural patterns to reduce phenomena to its simplest terms. Cultural understanding does not lend itself to simple descriptions and while it is the American way to reduce experiences to there simplest form it blocks our ability to comprehend complex cultural ways of the world or to see subtle differences.

(12) Diagnostic criteria used to understand symptoms of traumatic stress may not capture the various types and forms of exposure to traumatic stress and therefore reliance on DSM-IV-TR criteria may underestimate the presence of symptoms of psychological and emotional distress.

(13) Trainers might consider including symptoms of complex PTSD and Traumatic Stress.

(14) Training needs to incorporate the issues that arise from what I call "Dynamic cultural conflicts". The conflicts that occur between the dominant cultural norms and practices and that of other cultural ways.

(15) Counseling techniques taught to crisis teams should include knowledge about racial-cultural variations in verbal and non-verbal communications styles.

(16) Include consideration of American cultural patterns in training that influence our perceptions, language, thinking, and behavioral patterns.

(17) DMHAS has done commendable work and made considerable effort to reach out to and be responsive to racial-cultural communities as evidenced in its various treatment

programs and community outreach efforts. Yet the efforts must extend beyond what has been done and reach deeper into the respective communities.

(18) Training and treatment must be designed to enhance behavioral health professionals knowledge and understanding of the experiences of community members. Racial-cultural communities are not monolithic, people who reside there may vary with respect to level of acculturation, education, income, and racial-cultural identity.

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Disaster Response to Communities of Color: Cultural Responsive Intervention

The following is a review and discussion of critical issues involved in assessing and coping with traumatic events, in the general population and with communities of Color. According to the U.S. Census Bureau in the State within the major racial groups there are 4 ethnic groups for African Americans, 5 for Hispanics or Latino's, 28 White ethnic groups, 6 for Asians, 4 for Native Hawaiians and Pacific Islanders; American Indians were not listed with Nation affiliation. Training should therefore be focused to the racial-ethnic groups specific to the State.

Overview and History of Definitions of Trauma

The training material for behavioral health or first responders has as its focus the symptoms and signs of post-traumatic stress disorder (PTSD) that results from threatening life events. It might be helpful to consider discussing traumatic stress from a broader perspective than PTSD. The majority of the information about the signs and symptom of PTSD is accurate, valuable and useful. However, the information is limited in that the framework for understanding reactions to potentially traumatic life-events is based on the rather narrow criteria for diagnosis of PTSD or Acute Stress.

The experience of trauma as a consequence of life-events began to be recognized in the late 19th and early 20th century. At first incidents of trauma were recognized as resulting from combat (shell shock) and in civilian life railway accidents (railway spine) (Turnbull,

1998). As more social and physical science researchers worked to understand traumatic stress it became clearer that sources of stress would have distinct psychological, physiological and biological components. Biological researchers have found that exposure to life-events that produce a response that is characterized by post-traumatic stress disorder (PTSD) or high levels of traumatic stress are associated with distinct and unique biological or physiological and psychological changes. For instance, extreme stress reactions like PTSD involve increased adrenaline and decreased endorphin production thus resulting in increased muscle tension and greater awareness of pain.

The psychiatric and psychological community began to formally recognize that stress reactions followed life-threatening events in 1980's. The 3rd edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association offered a definition and the first set of criteria for a diagnosis of PTSD, one type of traumatic stress. Prior to the 1980's edition of DSM "gross stress reactions" and other reactions were acknowledged as basically resulting from overwhelming environmental stress. What made the 1980 classification of PTSD noteworthy was the application of traumatic stress to a wider variety of life-events such as assaults, disasters, and abuse. Evolution of the criteria for PTSD (DSM III-R, DSM-IV, DSM IV-TR) included consideration of additional symptoms and responses that were incorporated in the diagnosis of PTSD, criteria A is the exposure element for a diagnosis of PTSD. Included over time in the diagnosis of PTSD were psychological and behavioral avoidance responses and the requirement that the event be life threatening. Later, witnessing life-events was added to criteria A. The most recent edition of DSM-IV-TR requires six criteria for a diagnosis of

PTSD. In criteria A –an event is life threatening, if it results in a reaction of intense fear or helplessness or horror, which leads to impairment of functioning. Also needed for a diagnosis is criteria B, C, D, E and F. Criteria B, requires that the person re-experiences or has intrusive memories. Criteria C, means that the person engages in avoidance behavior and/or thoughts or tries to numb or push away the experience. Criteria D, concerns whether the person has reactions characterized by hyper-arousal or startle responses or sleeplessness. Criteria E, involves determining the duration of symptoms and requires that all of the symptoms (B, C, & D) must last for more than 1 month. Criteria F, is used to determine if the symptoms caused clinically significant impairment in life and work (Kubany, Leisen, Kaplan, & Kelly 2000). In summary, diagnosis of PTSD requires, exposure that is a threat to life, symptoms of intrusion or re-experiencing, avoidance or psychic numbing, and increased arousal.

The inclusion of witnesses of trauma offered broader classification criteria that included the reality that people who respond to disasters or traumatic events such as emergency workers or rescue workers may develop PTSD symptoms as well as people who are affected indirectly by the life-events that produce extreme stress.

Definition and symptoms of Traumatic Stress.

With the increased recognition of PTSD in various areas of life researchers began to investigate the incidence and prevalence of lifetime PTSD as well as recent exposure (within one year) to potentially traumatic life events that might produce PTSD symptoms. One objective of epidemiology studies of trauma, among the general population, was to

determine whether the definition or classification of a traumatic event could go beyond that provided by DSM criteria. Norris (1992) argued that a traumatic event could be defined as any event that is perceived or experienced by the individual as shocking enough to produce symptoms of intrusion, numbing, and arousal. Thus, Norris offered a broader and presumably objective definition of a traumatic event as "a violent event marked by sudden or extreme force from an external agent" (p. 409).

According to Carlson (1997) a variety of potentially traumatic experiences such as physical and sexual assaults, disasters, accidents, war, aggression, sudden death, and witnessing assaults, death and violence share three common elements that qualify a single or chronic event(s) as traumatic. The common elements are: (1) the perception that the event is negative; (2) the event is sudden in its occurrence and, (3) the event is experienced as uncontrollable. Carlson (1997) and others (e.g., Herman, (1992) offered alternative models for traumatic stress reactions because DSM (IV-R) definitions of PTSD, Acute Stress Reactions and other diagnoses were not applicable to all possible traumatic experiences. Researchers have found that people who develop traumatic stress reactions share three core elements of symptoms that may be expressed through a range of modalities (e.g., affective, cognitive, behavioral). The common elements are (a) intrusion or re-experiencing, (b) arousal and (c) avoidance or numbing (psychological). Re-experiencing, arousal and avoidance are expressed through cognitive, affective, behavioral and physiological modalities. For example one might have intrusive thoughts or images (re-experiencing) and loss of memory of the event(s) (avoidance), anxiety and/or anger (re-experiencing) and emotional numbing (avoidance); as well as aggression

or hyperactivity (arousal) and denial of the situation or place of the trauma (avoidance). Sleeplessness, startle responses (arousal), inability to concentrate (intrusion) are also symptoms associated with trauma reactions as are numbing of senses (avoidance) and flashbacks (intrusive re-experiencing), lastly symptoms may be expressed through a combination of modalities such as dissociative states and nightmares.

In addition to intrusion, arousal and avoidance people are also likely to have associated responses such as: depression as reflected in inactivity, negative thinking, hopelessness, and aggression such as frustration about inability to control anxiety or behavior that inflicts self-harm as a way to relieve the experience of being numb. Self-esteem may be affected by a loss of self-worth especially for children wherein the trauma disrupts developmental processes. Identity confusion or disturbance may characterize dissociative symptoms that led to a feeling of being detached from oneself. Interpersonal connections may also be disrupted and harmed such that one has difficulty in intimate, family, friendship and work relationships. Guilt and shame may arise due to blaming one's self for the traumatic event(s) and feeling responsible and disgraced by the experience (a reaction that might characterize people from cultural groups that have an emphasis on maintaining face and not disgracing the family or community).

Herman (1992) also proposed that consideration be given to what she called "complex post-traumatic stress disorder" this refers to traumatic experiences that are prolonged and repeated over long periods of time and that led to changes in one's personality structure. Usually one may observe alterations in systems of meaning, in perceptions of the

perpetrator, in self-perceptions, in forms of consciousness (e.g., dissociative episodes), and alterations in affect. Therefore, it might be of value to extend the definitions of traumatic stress in the training material to capture some of the broader conceptual models of traumatic stress.

<u>Research on Traumatic Stress and PTSD</u>

I reviewed a selected group of studies published between 1992 and 2002 (see reference list for details) that ranged in topic, population, goals, and type of issues discussed. For the most part all of the studies were reviews of the literature or empirical research studies that focused on issues of traumatic stress and/or post-traumatic stress in adults, adolescents and children.

The research and scholarship that address the responses to life stress fall into two broad categories. The first category includes studies that investigate the responses of war veterans to traumatic stress. In the second category are studies that investigated experiences of the general population that included both clinical and non-clinical groups, who respond to a range of interviews and self-report instruments, to assess reactions to life events such as natural disasters (hurricanes, fires, etc) car accidents, interpersonal violence (physical and sexual assault) and sudden death. Many of the studies sought to document the prevalence and incidence of a range of responses to traumatic life-events such as disasters. Some studies were undertaken to show that post-traumatic stress disorder could be applied across cultures (e.g., Carlson, Rosser, Hosan, 1994), others were designed to document the epidemiology of traumatic experiences (e.g., Breslau,

2001, Norris, 1992); while others were designed to discover what characteristics would predict the development of PTSD and other psychological symptoms in response to stressful life-events (e.g., Breuwin, Andrews & Valentine, 2000).

Norris' (1992) review of the literature found that estimates of lifetime PTSD in the general population ranged from 5% in non-combat situations to 15% for veterans. Other studies reported lifetime rates of PTSD at 1%, while a larger study of adults with revised measures found that the lifetime prevalence of PTSD in the general population was 9% and 39% were exposed to traumatic events of those 24% had PTSD. Variations in studies were due to methods used and definitions of traumatic events as well as symptom criteria used to establish the presence of PTSD or other psychiatric disorders. Most of the earlier studies were based on specific experiences to a disaster or to combat in the Vietnam War. However, while the range is wide (1% to 24%) most researchers report that after exposure to a potentially traumatic event, only a small portion (1% to 5%) of people develops PTSD.

Norris' (1992) study examined lifetime and past year incidence of traumatic events (such as physical assault, car accidents, combat, crime and fires). She used a racially diverse sample and assessed global or perceived stress and levels of traumatic stress (PTSD symptoms). She found that 69% of the people reported being exposed to at least one potentially traumatic event in their lifetime. In the past year 21% of the sample experienced a violent or traumatic event, with robbery being one of the most frequent. She reported that both gender and race differences were found in the response to stressful

life events. Women experienced sexual assaults at a greater rate than men, and men experienced physical assaults and car accidents with more frequency. Whites were more likely to be exposed to violent events but Blacks seemed to be more vulnerable to the stress of life-events.

Norris' findings were related to and extended by Breslau (2001) almost a decade latter. Breslau reported that PTSD affected 1 in 12 adults during their lifetime, which is about 15% to 24%. In one study of Michigan adults, exposure to a traumatic event in men was 43% and 37% in women using DSM-III-R criteria. The rate of PTSD for exposed people was 24% and the lifetime prevalence of PTSD in the sample was 9%. The finding of 9% prevalence rate was greater than previous studies. Breslau's review of the national co-morbidity survey found that a general population sample of over 5000 adults was used (15-54) and researchers found gender differences in lifetime prevalence of exposure to trauma. Males had a 61% rate of exposure to life-events that could be stressful and females 51%. Lifetime PTSD rates based on DSM-III-R after exposure were higher for females (10% vs. 5%) for males (Kessler, Sonnega, Bromet, at al (1995).

Perilla, Norris and Lavizzo (2002), studied a racially diverse sample of adults six months after Hurricane Andrew. They found that the prevalence of PTSD differed by racial and ethnic groups. Whites had the lowest PTSD rate at 15% after events; Latino's who spoke Spanish in the study had the highest rate 38%, and Blacks has a rate of 23%. These researchers found that differences due to race and culture accounted for the variations in PTSD symptom development. They noted that "{C}ulture-specific responses to

Hurricane Andrew suggest the need to view psychological symptoms in light of possible adaptive nature of the behaviors due to political, social, economic, and historical perspective" (p. 20).

Risk factors for developing symptoms of PTSD were reported by Brewin, Anchrens, Valentine (2000) who found that gender, age at time of trauma and race were weak predictors of risk. Education, previous trauma history, and childhood problems were consistent predictors of PTSD. Trauma was more severe and a stronger predictor of PTSD for children and adults when there was less social support and there was a history of other forms of life stressors (i.e., job loss, illness etc). For women, Green et. al., (2002) found that multiple traumas were related to higher rates of PTSD symptoms, a finding consistent for racial-cultural groups. Confirming the effects of prior exposure to trauma would be related to greater levels of PTSD. Duber and Motta (1999) reported that Black/Hispanic foster children with histories of sexual or physical abuse were more likely to develop PTSD symptoms then foster care children without prior histories of trauma.

Moreover, studies (e.g., Vernberg et. al., 1996) of racially diverse children exposed to a disaster, have reported that over 80% of children 8-10 years of age reported mild psychological symptoms that are within the PTSD classification criteria. Almost half of the children (55%) had moderate to severe symptoms. Re-experiencing was the most frequent symptom with some numbing and arousal. Researchers found that support from teachers; parents and friends were helpful in addressing symptom reduction. However, low levels of parental conflicts can moderate symptom development for children exposed

to disasters. Wasserstein & LaGreca (1998) found that greater conflicts among parents after exposure to a disaster were related to higher levels of PTSD symptoms in children. This finding was strongest for Hispanic children in comparison to Black and White children. Perhaps, revealing variations in cultural patterns among the racial-cultural groups studied.

While considerable attention has been given to PTSD diagnostic criteria, it is important to keep in mind that most people who are exposed to potentially traumatic life-events do not develop symptoms. Therefore, it is important to consider both cultural as well as individual difference variations. When considering both cultural and individual variations in responses to traumatic life events it is necessary to also rethink what we attribute as the casual event for developing traumatic stress reactions. DSM criteria require an identifying event to be the cause of PTSD. Bowman (2002) points out such definitions and descriptions of traumatic stress events do not consider the person's subjective experience as relevant. Furthermore, Bowman notes that a dose-response model or the severity of the external event alone does not adequately explain the exposure to traumatic or toxic events and the development of PTSD. If the severity of the event is high so should the prevalence of PTSD in those exposed. Yet studies show variation in exposure as well as in those who develop psychological symptoms of PTSD. Bowman argues that personal (or cultural) characteristics might be stronger agents in the dose-response relationship. The cultural groups' (or person's) history, beliefs and emotional reaction(s) may contribute to both adaptive and less adaptive responses. The

role of culture is particularly relevant for groups (or individuals) who hold strong beliefs in the power of external forces.

Racial and Cultural Groups Traumatic Stress and PTSD

This section of the report will address several issues. First I will define the terms used in this section and then discuss what is known about race and culture in mental health. Then I will briefly review a selected set of the published research that report on the prevalence and incidents of traumatic stress in various populations of Color.

In order to understand and respond to experiences of communities of Color, it is important to clarify the meaning and use of important terms such as culture, race, ethnicity as well as traumatic stress and PTSD as they are applied to the experience of people of Color. The reference to people of Color refers to historically disenfranchised Americans, Black/African, Hispanic/Latino, Asian/Pacific Islanders, Native-Indigenous Americans. People of Color also include immigrates and refugees who have migrated to this country.

Defining race-culture-ethnicity

My use of culture refers to patterns of meaning reflected in a worldview (a way of understanding the universe and peoples place in the universe). Culture has associated with it a system of meaning, values, norms, behaviors, language, and history that is passed on from one generation to the next through socialization and participation in the group's organizations and institutions. Ethnic group usually refers to one's nation of

origin or a religious group (Jewish). Racial groups are identified on the basis of skin-color, physical appearance and language (Carter, 1995). Race is also thought to reflect a group's culture mainly due to race-based separation and group isolation. American racial and ethnic groups were socially and legally separated for centuries and were therefore able to retain and sustain distinct cultural patterns and preferences.

Race also has psychological meaning for group members and the meaning attributed to one's racial group membership (one's racial identity) may vary from individual to individual (Thompson & Carter, 1997). Race is, more than anything else, a socio-political designation that has deep historical and socio-economic and political roots. We often use race as a short hand reference to culture when discussing the dominant racial categories (i.e., Whites and People of Color) in the United States. Researchers often use the terms race, ethnicity and culture interchangeably, which is often confusing and I think inaccurate. Nevertheless, I will attempt where possible to make distinctions using the definitions I have presented.

Definitions of Traumatic Stress applied to People of Color

There are two ways to understand and identify extreme stress reactions, one way is to use the criteria of DSM and the other is to use the concept of traumatic stress (discussed above as including traumatic stress, complex and partial PTSD), which does not fit the diagnostic criteria of post-traumatic stress disorder PTSD, or Acute Stress Reactions or other diagnosis. Scholars have argued that many life events might product stress reactions that are experienced by some as traumatic. The constellation of signs and

symptoms of stressful life-events usually do not meet the narrow diagnostic criteria set forth in DSM. But some reactions to life events and war zone exposure do meet the criteria for diagnosis based on DSM guidelines. Nevertheless, Herman, Carlson and others have argued that broader criteria be used in assessing traumatic stress. They argue for consideration of what some call complex PTSD or reactions of traumatic stress that are characterized by experiences that are negative, sudden and uncontrollable and that include a range of symptoms and responses (discussed above; Carlson, 1997).

Culture and our Daily Lives

There is acceptance by many professionals that in our cultural, social environments shape who we are and how we behave and feel in the world. Often our culture is reflected in our neighborhoods and communities. Many communities of Color have historically been segregated. Today many are still subject to external forces that maintain their social separation, while other communities may exist as distinct enclaves by choice. Nevertheless, our experiences as members of racial-cultural groups in society, as well as our personal understanding of that experience (i.e., one's racial-cultural identity), affect our mental health.

Our cultural context (race, ethnic group, gender, religion, language, social class and so forth) influences how we understand health and mental fitness. Our culture also determines what is considered normal and abnormal. The circumstances we encounter in society, such as access to work, shelter, and health care, influences our understanding of our experience and how we function in our communities and in society.

It is important to acknowledge at the outset the elements of American culture or worldview that characterize our society and dominates our belief system, behavior and expectations. We are Americans and as such our culture has evolved from White ethnic values and beliefs. American cultural systems are super-ordinate to ethnic group values. Some of the dimensions of White American cultural patterns are according to Carter (1995; 2001) individualism, a focus on personal preferences; self-expression based on externally defined accomplishments and conformity to social norms; systems of power based on hierarchy and communication through standard English; a time orientation focused on the future that treats time as a commodity; a religious system based on Judeo-Christian ideals; and preference for nuclear family structures; and aesthetics and traditions that are based on European cultures. Thus, our way of understanding health both physical and mental is based on the worldview that characterizes our culture and is embedded in our professions and institutions. What has been learned about cultural influences on physical and mental illness? We have learned that people with schizophrenia do better in developing countries than in North America. Close to 60% of people in Nigeria and 50% in India diagnosed with schizophrenia were better or were in remission after 2 years. Anthropological and cross-cultural studies show that cultural beliefs about what mental illness is, affects its course and treatment. Indians, Africans, and Mexican Americans see people who may be schizophrenic as ill and vulnerable. For them the illness is related to sensitive nerves or other factors and one can recover from it or chase away the spirits that may be responsible. For White Americans a person with the illness of schizophrenia is seen as “crazy” with no hope for recovery.

Race and culture may also influence diagnosis researches find but cannot explain that Black African/Americans are more often diagnosed with schizophrenia and are less likely to be seen at having affective disorders. Researchers argue that this reflects cultural bias on the part of many clinicians (irrespective of racial-cultural group membership) who are socialized and taught during professional development to see people of Color and Blacks as more disturbed then Whites.

Symptoms of disturbance may be experienced and expressed differently by members of distinct cultural groups. Thus, some members of groups that culturally believe in and interact with spirits or that believe in a world that is not completely objective, may relay experiences (i.e. talking in tongues, communicating with tress, hearing from the dead, etc.) that are often seen from a White American cultural perspective as signs of mental illness.

There is a belief that findings from studies of majority group members, apply with no variation or are universal. Thus, the expression of illness found from populations of mentally ill people of the majority culture are assumed to be true of all people irrespective of race, culture, and ethnicity; a belief that has been questioned and shown to not be valid. Decades of research make it quite clear that, however universal categories (e.g., depression etc) of mental illness may be, the patterns of onset and duration and even the nature and clustering of specific symptoms vary widely across cultures.

There is variation in how people of different cultures view and understand self or personal identity. Among many Asian cultures the self is interdependent. In North American culture, the self is primary individual and internal. Notions of self and personal identity influence mental health. In Asia one's relationship with others, matter a great deal and affects one's mental health. If the relationships are strong and productive so is one's sense of self, if not, mental health may suffer. In the U.S. there is greater emphasis on one's unique personal attributes and how one functions internally has greater implications of mental health.

We are regardless of culture, humans and therefore share common physiological and neuro-chemical systems. Thus, some expressions of emotional do seem to characterize human experience. However, subjective experiences associated with particular emotional expressions vary by culture. For example, for U.S. residents posing and expressing negative and positive effect was found to be associated with changes in mood according to the emotion. It was found that positive subjective feelings went with the posing of positive facial expressions. The same was not true for members of non-Western cultures the poses of negative and positive facial expression did not affect their subjective feelings (NIMH, 2003).

Overt discrimination and prejudice is contrary to our legal codes and for some does not exist in the daily life experiences of people of Color. Yet research shows that racial-cultural discrimination is still a factor in the lives of people of Color and that racial

discrimination increases their levels of stress and contributes to psychological symptoms. Discrimination occurs in housing, employment opportunities and health care.

Members of racial-cultural groups vary in the level of identification and investment they make to one's group culture, acculturation to the dominant culture and levels of psychological identification with the racial group vary by individual and the variation influences the meaning and significance of the group and its culture for the individual person. Social–economical resources also influence the vulnerability one has to stressors of life-events. Fewer resources and lower social status seems to be associated with greater vulnerability to life-event stressors. One's community and its organizations can have positive and negative affects on mental health. Support systems and organizations that address and seek to reduce the effects of social, personal, and economic resources can protect its members from the harm of stressors and reduce the incidence and prevalence of negative mental and physical health outcomes.

It is easy to see differences when people speak another language, or wear clothes that are different, or are visibly different. It is harder to see and understand cultural differences in perception of the world, in thinking, and in interpersonal relationships. It is more difficult within the context of American society, where we might assume some cultural similarity.

> *Dynamic cultural conflicts should be identified and addressed. Dynamic cultural conflicts are when two cultural styles are operating at the same time but in contradiction to one another.*

It is imperative that cultural competence be seen and taught as a complex process. Trainers must be made aware of the American cultural norm of reducing an issue to its simplest terms. It is culturally appropriate to do so - since it is part of our culture. The dynamic conflict is that complexity must be embraced to grasp another culture's worldview. Thus, for Americans we would reduce a new culture to its bare essentials, which is consistent with our cultural patterns. However, it is contrary to grasping and learning another's culture. We must allow complexity to exist to learn about cultural influences and avoid or suspend our style of reducing things to simple terms. For example, as American mental health care professionals we are taught to separate our professional and personal lives. Yet to learn about race and culture we are often asked to explore our personal experiences and beliefs that is a violation of our cultural norms and a dynamic cultural conflict.

Usually when we are asked to learn about something we are focused on what it is and how it works. Learning about other cultural experiences I believe requires that we learn about ourselves, a dynamic cultural conflict. We are not accustom to revealing ourselves or being the focal point of learning. Nevertheless, cultural learning is most effective when it is primarily self-exploration. The more aware you are of your cultural norms, values, communication styles, the easier it is for you to consider and grasp another way of seeing the world. It is difficult to help the FISH learn that it is in water and you are not. From the perspective of the FISH there is no other way to be. And it is likely that the world is not seen as water - just as the world. If on the other hand you believe that without

examination that the world is as you see it and no other way. It will be difficult to see the world through another racial or cultural lens. It will be difficult to learn and understand another cultural worldview or another way to communicate, another way to behave, or react.

The Research Literature on Traumatic Stress and PTSD and People of Color

As was true with the general prevalence literature the race-specific research also are of two types those of war veterans and experiences of clinical and non-clinical adults, adolescent and children who were exposed to a range of life events such as natural disasters (hurricanes, fires, etc). Many of the studies reported above also found and reported on racial and cultural differences in the prevalence and incidence of traumatic stress to life-events.

I have presented some of the epidemiology research in terms of the proportion of the general population that develop psychological symptoms after exposure to a life-event perceived as stressful. In general, between 1 and 9% in some studies and as high as 24% in others have symptoms associated with lifetime PTSD while about 20% of citizens experienced a stressful response within the last year. However, Norris (1992) also found that in a general population sample, there were racial differences in response to traumatic life events in particular, perceived stress from exposure was highest for Blacks and Black men in particular. When considering the impact of stressful events race differences in extreme stress were not found. The impact of stressful life events was strongest for Blacks. Blacks exhibited the highest levels of stress. Other studies have found Blacks to experience fewer traumas. Norris argued that conflicting findings point to the need for

specifying the cultural context in which trauma occurs.
Regarding trauma assessment she found that victims needed to meet all three symptoms of criteria C (avoidance, helplessness, and numbing) in order to meet the criteria for PTSD. She noted that as a result of using the present diagnostic system, intrusiveness and arousal seem to be judged to be clinically insignificant unless a very diverse set of outcomes is present. The rates for PTSD would double if at least two rather than three (3) symptoms were sufficient for criteria "C".

Breslau (2001) also reported that Black men "appeared to be the most vulnerable to the effects of traumatic events" (p. 117). Studies of the effects of life events in other racial/ethnic communities found that American Indians are exposed to violence and other stressful life events at rates higher than other racial-cultural groups. In one study of Southwestern Indian community the prevalence of lifetime PTSD was 22% and 82% of the sample of 201 respondents experienced at least one lifetime traumatic event. These rates are higher than in the general population. Many of the respondents had experienced multiple traumatic events and repeated traumas were predictive of PTSD.

In a study of Plains Indian, adolescents who resided in the North Central part of the U.S, it was reported that 61% (66) of the 109 respondents reported having witnessed or had a direct traumatic experience event. Most reported multiple events (62%) car accidents and death were the most frequent. Of the group that reported a traumatic experience, more than half (50%) reported 1 to 3 symptoms and 17%, reported more than six symptoms of PTSD. Re-experiencing (50%) was most often reported followed by intrusion (47%) with

considerable emotional distress. Arousal was seen in 17% and 8% reported avoidance or numbing symptoms. Yet overall only 3% of the total sample met the criteria for a diagnosis of PTSD (from DSM-III-R).

Researchers have also reported on ethnic groups exposed to traumatic events. Some of the ethnic group findings were that Cambodian adult refugees were found to have high levels of psychological symptoms due to the stress of relocation mostly depression and anxiety. PTSD reactions were related war related trauma. For instance, in one study of 50 adults 94% of the sample endorsed 50% of 14 PTSD items. Eighty percent (80%) had high scores for depression, anxiety and disassociation. Eight six percent (43 of 50) met the DSM-III-R criteria for PTSD and emotional distress. Many of the symptoms that were reported tended to be somatic.

In a study of 209 Cambodian adolescents, 194 or 93% reported having had a traumatic experience. Assessment of symptoms of psychological distress was determined by using an interview schedule of both parents and the adolescents. The investigators used various items to construct symptoms clusters for the sample and to determine if the items clusters were valid across generations and within the cultural group. It was found that intrusion; numbing, avoidance, and arousal factors were related to PTSD symptoms. Results suggested that depression was more likely to me associated with resentment and PTSD was related to the traumatic experiences associated with the war.

In a recent study (Piotrkowski & Brannen, 2002) of school personnel in New York who saw the Towers collapse, or know someone who was either hurt or died, during the 9/11 disaster. Investigators examined whether indirect exposure was related to diversity of symptoms of PTSD or if the perception of threat effected respondents who may have had less direct exposure. The respondents were 124 Black and Hispanic men (33%) and women (76%). In essence what was studied was the meaning people attached to the events. Researchers asked whether people's sense to safety in the world was altered, if people felt less confidant and in control of their lives, and if they felt worried about threats in the future.

Investigator found that 14.5% of the sample met criteria for PTSD symptoms. Respondents reported 4.5 symptoms of PTSD on average. 16% reported no symptoms and 37% reported 1 to 3 symptoms, 28% 7 or more. Only a small number 1 in 6 or 16% reported seeking professional help. Of those who did seek help they had more severe symptoms than those who did not. More importantly, however, 61% of those who met the criteria for PTSD did not seek professional help. High rates of PTSD were found along with high numbers of sub-syndromal or partial symptoms of PTSD.

Risk factors were also tested in the (Piotrkowski & Brannen, 2002) study such as demographic variables, subjective variables like threat appraisal, feeling the world is unsafe, lost of personal confidence and degree of exposure to the attacks. Results showed that exposure, appraisal of threat, and lost of confidence were predictive of symptoms of PTSD. Higher exposure to the attacks, those who thought the future would bring more

attacks, and those who lost the most self-confidence had higher PTSD symptoms. The groups studied were not directly exposed to the events of 9/11 yet they had high levels of partial and as well as diagnosable PTSD symptoms. And many did not seek help for the symptoms they reported experiencing.

Multiple group comparison studies that included Blacks tended to find, that in comparison to other groups, Blacks had higher rates of exposure to interpersonal violence. One study compared Blacks, Hispanics and White undergraduate students and found that 39% of the full sample reported direct exposure to at least one violent non-sexual event and 44% had direct exposure to one violent sexual event. Based on severity ratings 14% met criteria for lifetime PTSD. By racial group 22% of Blacks, 12% of Whites, and 13% of Mexican Americans met criteria for PTSD. Blacks had significantly more exposure as primary & secondary victims of both sexual and non-sexual violence.

Perilla, Norris and Lavizzo's (2202), study of reactions by racial groups after Hurricane Hugo examined differences between acculturated Latino's (defined as English-preference is study interviews and instruments) and less acculturated (those who participated in the Spanish -language). Moreover, these researchers looked at specific symptoms manifestations. In general, participants were found to have three times the rate (24%) of PTSD symptoms than found in national samples (8%). The higher rate of PTSD was thought to more likely than not to be related to the distress brought by the storm. Racial-ethnic groups were more distressed than Whites, Latino's more distressed than African-Americans, Spanish speaking more distressed than English speaking Latino's.

Regarding specific symptoms Perilla et al, found that Whites were least likely (58%) to meet Criteria B (Intrusion) and Spanish speaking Latino's most likely (89%). A similar pattern emerged for avoidance symptoms Criteria C. A different pattern arose for arousal (criteria D) Whites and non-whites did not differ but African-Americans had higher levels of arousal symptoms, eighty percent (80%) had a least two or more arousal symptoms than did Latino's. The trauma experienced by Whites in the study tended to be less personal and less often related to neighborhood trauma whereas Blacks and Latino's experienced greater levels of personal and neighborhood trauma. For people of color they experienced more severe trauma and that severity was related to developing PTSD. Perilla, Norris and Lavizzo found that neighborhood trauma added to the personal trauma of People of Color and was uniquely related to the specific symptoms of avoidance, intrusion and numbing, suggesting that people of Color maybe more effected by community losses than Whites. Furthermore, the difference in specific symptom manifestations such as greater arousal for Blacks and greater levels of intrusion for Latino's seems to provide evidence of culture-specific patterns of symptom expression.

For studies that examined Black/African-Americans few considered ethnic group variations. Black South Africans were found to have altered assumption about the world due to exposure to torture and detention.

Veterans

In 1990 the National Vietnam Veterans Readjustment Survey (NVVRS) studied veterans who were exposed to war zone combat, the survey found that, 15% of the total group had current PTSD symptoms and 31% had lifetime PTSD. Among the soldiers of Color the NVVRS found that 21% of Black, 28% of Hispanic, and 14% of White veterans had diagnosable PTSD as well as other psychological symptoms. In studies of the lifetime rates of PTSD among Southwest American Indians veterans was 45% and 57% among Northern Plains Indians and 38% among Native Hawaiians. Researchers accounted for pre-military factors such as childhood problems, being poor, prior affective disorders, and substance abuse and still found that the prevalence rates for Veterans of Color were still high. Controlling for combat exposure resulted in the differences in prevalence rates being reduced with Soldiers of Color having much higher exposure to war zones then Whites. But among Hispanics the rate of PTSD for veterans was the highest of any racial/ethnic group and was not accounted for by war zone exposure. Another racial comparison study of combat stress found the rates for PTSD were 30% for White and 47% for Blacks and that Blacks reported significantly more childhood trauma than did Whites.

Loo et al (2001) measured three types of race-related stress in Asian American veterans. Prejudice and stigmatization (personal experiences of discrimination), bicultural identification and conflict (dealing with being both Asian and American), and a racist environment (witness to verbal or behaviors of discrimination), these were associated with war zone exposure and psychological symptoms and PTSD symptoms to determine

if race-related stress contributed to psychological distress and the development of PTSD. They found that 37% of the 300 participants in the study met the criteria for a diagnosis of PTSD. Moreover, high levels of psychological symptoms were correlated with low rank and high combat exposure. When measures of race-related stress were added as subscales and full-scale scores. The prediction of PTSD and psychological symptoms was improved. The results supported the hypothesis that for Asian American Vietnam veterans' perceived race-related stress contributed to general psychiatric and PTSD symptoms. In fact race-related stressors were stronger predictors of PTSD symptoms than exposure to combat suggesting that personal experiences of racism are potent risk factors for PTSD.

Among Hispanics the rate of PTSD for veterans was the highest of any racial/ethnic group. Among the ethnic groups studied Central Americans, from war torn countries had a 52% rate of PTSD in comparison to other immigrants from the region who had a 49% rate of PTSD, and Mexican Americans were found to have a 25% rate of PTSD. Among Hispanics veterans Ruef, Litz & Schlenger (2000) reported that 29% of Mexicans had PTSD, 28% of Puerto Ricans and 22% from other ethnic groups.

In summary, the reviews of the literature show that some people who are exposed to life events that might be stressful only some experience such events as traumatic and develop psychological symptoms. The general rates of developing PTSD after exposure to a potentially traumatic event are about 5-10%. People who had previous exposure to assualtive and other forms of violence are at greater risk for developing PTSD. People of

Color, experienced higher rates of PTSD after exposure to traumatic events and their symptoms were more severe. Veterans of Color have higher rates of PTSD and other psychological symptom of distress not explained by the specific exposure to trauma. The high rates of traumatic stress experienced by people of Color are explained by exposure to race-related stress in the form of discrimination and racism. Researchers suggested that People of Color are confronted with hostility, neglect and racism that may heighten the effects of life event crisis. Whites have greater exposure to traumatic life events and their social status seems to buffer the impact of the life events that might produce stress for them.

Training and Treatment Issues

Treatment to reduce symptoms of exposure to traumatic events has been found to be effective provided that caregivers have the proper training - training that is culturally competent. There are several issues that should be considered in the training of behavioral healthcare providers. Many have been used and taught by CTRP based on DMHAS' culturally competent models of care.

Intervention to reduce symptoms of exposure to traumatic events is more effective (Lamprecht & Sack, 2002, Turnbull, 1998) when given in close proximity to the event, and when administered by a range of helpers coupled with strong systems of support. It is important to follow acute interventions with follow-up long-term care. All of which currently exist in the operations plan for responding to disasters.

Communities of Color partner organizations have told us that they are deeply concerned about threats of future attacks and how they will be treated in the event of other disasters. Training and treatment models designed to respond to communities of Color must first be responsive to their voices and expressed concerns. DMHAS has done commendable work and made considerable effort to reach out to and be responsive to racial-cultural communities as evidenced in its various treatment programs and community outreach efforts. The efforts to connect with the community are good starts. Yet the efforts must extend beyond what has been done and reach deeper into the respective communities.

Attention needs to be given to how people feel about first responders and members of crisis teams. Assessments should be undertaken to determine how each group could be most effective. Said another way, entry and connection to underserved cultural groups could be enhanced and facilitated by pre-disaster involvement and system interactions that would be aimed at reducing or healing existing sources of trauma.

We learned from organizational representatives from communities of Color that each community has distinct needs, that each has existing fears and distrust, and each community reported greater anxiety after 9/11. Much of what they told us is confirmed by research studies, reviewed previously.

Training and treatment must be designed to enhance behavioral health professionals' knowledge and understanding of the experiences of community members. Members of racial-cultural communities are not monolithic in fact there is considerable variation with

respect to level of acculturation, education, income, and racial-cultural identity. Nevertheless, many people were anxious and fearful about immigration issues, wounds of old and repeated traumas were opened, particularly people from war torn countries. For, some racial-cultural groups, life-events associated with daily survival were sources of considerable trauma. Research findings have shown that people who live in isolated communities experience high levels of stress that often leads to psychological symptoms. Among the areas of stress, as listed by the presenter's, were housing, transportation, health care, and discrimination in interactions with institutional authorities such as the police. Also, mentioned was the reality of cumulative traumatic experiences that built deep and strong feelings of distrust for many community members.

Thus, the work outlined in this report required to respond to disasters in communities of Color has begun by the efforts of DMHAS and CTRP. My report includes feedback on manuals and offers conceptual guidelines for training drawn my own writing and research as well as from the mental health literature. It is my hope that the material contained herein will help enhance Connecticut's effort in providing its residents with psychologically appropriate and culturally relevant behavioral health services.

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