

Conducting Research in Diverse, Minority, and Marginalized Communities

Russell T. Jones, James Hadder, Franklin Carvajal, Sara Chapman, & Apryl Alexander

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“DRAFT”

INTRODUCTION

In order to more clearly ascertain the impact of disaster and other related terroristic events on minorities and marginalized communities, it is important that researchers strategically design and carry out studies to produce meaningful and valid databases. It is hoped that such data will be used to inform culturally, racially, and ethnically sensitive intervention efforts. The justification for the establishment of such databases is based on the following three factor: (1) the dearth of post disaster samples the have included sufficient numbers of people of color and marginalized communities, (2) the prevalence of trauma among people of color and other

marginalized communities, and (3) the hypothesis that these groups are at greater risk following disaster than other groups and therefore the need for greater research attention. Each factor will be expounded on below.

In regards to the status of post disaster samples, minority populations and marginalized communities are seldom represented in disaster research studies. Unfortunately, there appears to a general neglect of such groups on the part of disaster researchers. As concluded by Norris and Alegria (2005), “research on the epidemiology of depression and PTSD is inadequate.” (p.2). For example, while concerted attention has been given to Posttraumatic Stress Disorder (PTSD) within the general population (American Psychiatric Association, *DSM-IV-TR*, 2002; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995), relatively little study have been given to rates of trauma exposure and prevalence of PTSD among African Americans (AAs). Thus, the need for attention to the area of minorities and trauma is obvious. In fact, it is morally imperative that concerted effort be brought to bear to assist those who are often most vulnerable and endure the greatest hardships following disaster.

In light of the elevated rates of trauma exposure in economically disadvantaged minority urban environments (Breslau et al., 1998; Selner-O’Hagan, Kindlon, Buka, Raudenbush & Earls, 1998), it is quite likely that minorities would have a greater prevalence of trauma. This notion is certainly supported by the re-analysis of the National Comorbidity Survey (NCS) as well as the Epidemiologic Catchment Area Survey (ECA) that documents the elevated prevalence rates for major depressive disorder among adult Hispanics living in the United States, Non-Hispanic whites, African Americans, and Asian Americans (Holzer & Copeland, 2000).

The oft-held hypothesis that members of minority and marginalized communities are at greater risk for negative outcomes following such disaster-related events than others in the general population (e.g., Norris & Alegria, 2005), is an interesting one. Factors related to ethnicity, culture, and race may negatively predispose these groups to elevated levels of distress and psychopathology following both natural and technology disasters. Additionally, a host of other predisposing factors including racism, discrimination, experience and diathesis may also render these individual more prone to negative outcomes resulting from such events. For example, given that we know that AAs have higher levels of cardiovascular reactivity in response to a wide assortment of behavioral stressors (Anderson, McNeily, & Myers, 1992), coping styles (Parker & Jones, 1999), and social status (Anderson, 1991), such factors may also be operative in disaster scenarios. In sum, each of these points makes a compelling case for the need for additional research to address the issues presented.

With regards to prevalence, the issue of whether the relative prevalence and expression of certain psychiatric disorders is the same across ethnic/racial groups is yet to be adequately addressed (Breslau et al., 1998; Kessler et al. 1995). This question can only be answered through systematic investigations targeting members of minorities and marginalized communities by trauma researchers. For example, in a study by Perilla, Norris, & Lavizzo (2002), following Hurricane Andrew, culture was found to have an effect on the types of symptoms minority groups displayed. AAs tended to express distress in terms of arousal, while Spanish-speaking people express distress symptoms related to frightening experiences. Interestingly, Lawson (2000) suggested that PTSD symptom expression in AA might be different and result in misdiagnosis of schizophrenia among other disorders. Whereas prevalence rates of phobias and

somatization, under-recognition of depression, and increased suicides among AA youth have been obtained (U.S. Department of Health and Human Service, 2001a), similar efforts are needed in the disaster/trauma area.

Unanswered questions pertaining to the differing vulnerabilities to PTSD and other disorders resulting from disasters on the part of certain racial and ethnic groups leave important gaps in the trauma literature. For instance, the relative impact of race, female gender, exposure levels, preexisting psychiatric disorders, family history of psychiatric disorders and childhood trauma, exposure to violence, race-related stressors, lack of support, and decreased utilization of mental health services are yet to be systematically examined (Breslau, 2002; Vernberg, LaGreca, Silverman, & Prinstein, 1996). In our program of research investigating the impact of fire-related trauma, we have highlighted the need to study further the influence of gender, race, socio-economic status, social support, parent's reactions and coping on AAs functioning following such events (see Jones & Ollendick, 2002, for a review).

The examination of race-related stressors that include intra-psychic, social and economic effects of racial prejudice or stigmatization as well as bicultural identification (Jones, Brazel, Peskind, Morelli & Raskind, 2000; Loo, 2003) may be essential to the discovery of linkages between risk factors and symptom expression. In fact, Loo et al. (2001) reported that when clinicians fail to assess for race-related stressors, up to 20% of a patient's PTSD symptoms will not be referred to the appropriate diagnostic category namely, PTSD. Lastly, the need to study treatment efficacy among these groups remains an important under researched area. The dearth of outcome studies including clinical trials, psychotherapy, and cognitive behavior therapy has been embarrassingly great

(Zoellner, Feeny, Fitzgibbons & Foa, 1999). Issues related to the retention of these groups in therapy are yet to be systematically examined (Rosenheck and Fontana, 1995).

In summary, the scarcity of knowledge regarding minorities' functioning following disaster is sufficient reason for researchers to begin targeting this area more aggressively. To do so, a major hurdle to be overcome is the challenges of mistrust, barriers to access, and cultural and linguistic issues faced by these groups. Hence, the purpose of the present chapter is to discuss: (1) three major barriers to research among minority/marginalized communities (i.e., mistrust, access and culture/linguistics), and (2) solutions to facilitate the conduction of research with these populations following disasters.

MISTRUST

Perhaps one of the greatest barriers for researchers is the lack of trust. When asking a group of minorities why they did not participate in research, Roberson (1994) documented the three most frequent responses: fear, mistrust, and a lack of knowledge about scientific research. African Americans' fear and mistrust of researchers has been well documented. Gamble (1993) noted that, as early as the 1920's, AAs avoided entering hospitals for fear of being used as test subjects. It is not unreasonable to suggest that AAs' reluctance to participate in the white medical/scientific community's research programs may be a product of the historical relationship between them and Whites in the United States (in particular, the social and medical abuse that has been visited upon African American populations; Shavers-Hornaday, Lynch, Burmeister, & Torner, 1997).

The horrific impact of the Tuskegee Study where infected AAs were neither informed of their disease status nor treated (King, 1992) remains a constant reminder to this community of potential abuses of science. In a survey of 220 AAs, Million-Underwood, Sanders, & Davis (1993) found that 57% of respondents were either (a) of the opinion that scientific research was unethical in the United States, or (b) wary of scientific research, but felt that they required more information to make a more definitive judgment.

Bonham (2002) also documented forms of distrust with other minority and marginalized populations. For instance, undocumented Latino immigrants reported fear of deportation and, therefore, were naturally wary of strangers who approached them to provide information on a given issue (Marín & Marín, 1991). A related reason Latinos may be wary of research is the fact that they are frequently targeted by unscrupulous business organizations (Marín & Marín, 1991). These organizations often prey on the fact that many Latino immigrants have difficulty understanding marketing practices in the United States. Telemarketers seeking to sell their products often call them. This common practice may lead to a higher distrust of personal calls made by research interviewers.

A related area of mistrust has been in the domain of treatment. Here too, mistrust has been an impediment to successful recruitment of minorities to research related endeavors. For example, Corbie-Smith, Thomas and St. George (2002) found AA reported a greater distrust than Whites using a 7-item index measure. This finding remained even when controlling for social class. Factors including mistrust of physicians, cultural misunderstandings, misdiagnoses of illnesses and financial constraints collectively contribute to mistrust on part of minority groups (Boulware, Cooper, Ratner, LaVeist & Powe, 2003; Johnson, Saha, Arbelaez, Beach & Cooper, 2004).

ACCESS

With regards to access, for those members of marginalized communities who are not “totally turned off” by the mental health profession for reasons stated above, practical issues ranging from “stigma” to “taking time off work to talk with researchers” often present major barriers. Additionally, not being familiar with the “research process” nor its relevance for intervention may also serve as a major obstacle.

Perhaps an even greater barrier to access is the lack of resources. What’s worse is the fact that in times of crisis, availability of such resources is likely to be significantly lessened. The fact that minorities are more likely than Whites to be uninsured (Institutes of Medicine, 2000) is a primary explanation for this situation. Additionally, the array of social, demographic, and geographic barriers also prohibit racial and ethnic minorities from receiving needed attention following disasters. In sum, these factors make for very bleak outcomes for members of these communities following disasters.

CULTURE AND LINGUISTICS

The third major barrier to be addressed in this chapter relates to the areas of culture and linguistics. Disaster researchers’ lack of attention to issues related to these constructs has left huge gaps in their knowledge base and ability to work effectively with marginalized populations. Culture and linguistic competence defined as “a set of congruent behaviors, attitudes, and policies that

come together in a system, agency, or among professionals that enables effective work in cross-cultural situations,” (p. 1) should be an essential ingredient in the trauma researcher’s “tool kit.”

Researcher’s inability to address issues related to culture is a major hindrance to progress in this area. For example, his lack of understanding, and appreciation of constructs of thoughts, communications, actions, customs, beliefs, values, and institutions of those represented in marginalized, minority and underserved groups seriously jeopardizes his access to these groups. Without careful consideration to culture, our research paradigms, data collection methods, and interpretation of findings will continue to be significantly flawed. The interpretation of variables including, gender, social support, coping, family environment, and family composition must all be examined through “cultural lenses” if valid conclusions are to be drawn.

Language has also proven to be a major barrier for non-English speaking individuals to mental health care. Language refers to words, syntax, and local idiomatic expressions as well as symbols and concepts shared by the cultural group (Jones et al., 2001). For example, a major obstacle for Hispanic and Asian Americans is the absence of bilingual mental health workers. Nearly 1 out of 2 Asians Americans has difficulty accessing mental health treatment because they do not speak English or cannot find services that meet their language needs (U.S. Department of Health and Human Services, 2001a). This shortcoming is certainly mirrored in many disaster research efforts.

Consequences of linguistic problems have resulted in misdiagnosis and poor quality of treatment (Norris and Alegria, 2005). Frequently, immigrants who have trouble communicating in English are more likely not to receive care (Norris and Alegria, 2005).

Additionally, many instruments used in assessment rely on an understanding of the English language, which makes it impossible for a non-English speaking individual to participate in research activities. Consequently, there is a strong need to devise and include Spanish-language instruments for Hispanic Americans (Perilla et al., 2002) and others from different cultures. Furthermore, clinicians and researchers need to understand the meaning of body-language, gestures, postures and inflections within a minority group as to increase the success of rapport building.

SUMMARY

These challenges present major obstacles to the research enterprise, including recruitment, assessment, interpretation of findings, and integration of findings into valid treatment efforts. Solutions to overcome these obstacles are becoming of even greater importance in light of the fact that the United States is becoming more ethnically and racially diverse than ever before (Betancourt, Green & Carrillo, 2002). The fact that a disproportionate number of these individuals are represented in the 45 million uninsured Americans makes this issue an even more significant one. As bleak as this picture may appear in light of the barriers of mistrust, access, culture and linguistics; there are potential solutions that can help trauma researchers gain access to minority/marginalized populations. Suggestions for each barrier will be presented in the following section.

SOLUTIONS

In light of the fact that there exists no empirically validated model, which spells out guidelines for trauma researchers to address issues related to mistrust, access and culture/mistrust unique to minority groups and marginalized communities, we are proposing a model entitled: “Cultural Competence Model for Accessing Minority and Marginalized Communities Impacted by Disaster.” (See figure 1). This “working” model is based on the “Dose-Response” notion whereby the greater the impact of the disaster, the greater the likelihood of more negative outcomes. This model is similar to our model used in our exploration of child and adult survivors of residential fire (see Jones & Ollendick, 2002). Given that the major focus of this framework is minorities and marginalized populations, we feel that the relationship between the “Event” and the “Outcomes” is influenced (mediated or moderated) by the availability of resources (i.e., mistrust, access, and cultural/linguistic capabilities) to address challenges that have long plagued minority communities. With reference the third step in the model, “Resources,” we hypothesize that the extent to which such resources are afforded by the culturally competent approach; the greater the likelihood that challenges will be lessened. Consequently, “Outcomes” at the Acute, Data Analytic and Recovery phases will be more desirable.

A major predictor of success within this model is the overarching emphasis on a “Culturally Competent Perspective.” Betancourt et al. (2002) define cultural competence as “the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.” (p. V).

It is viewed as a vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share. We strongly suggest that a cultural competence perspective serve as the lens through which disaster-related initiatives are conceptualized and implemented. If disaster researchers are serious about learning more about the nature and course of the impact of disaster on minorities and marginalized communities, it is essential that such a framework be adopted. We feel that its adoption and implementation will lessen the negative impact of the obstacles of mistrust, barriers to access, and cultural and linguistic challenges. Solutions for each challenge will be presented in turn.

MISTRUST

From the perspective of our model, the following three suggestions are presented which may assist in remedying issues resulting from mistrust. First of all, the reader is directed to the list of recommendations in Appendix A for a list of very practical suggestions including; assessing and discussing levels of distrust, involving community gate keepers, and articulation research project's benefit to community members. Secondly, it is important to recognize the fact that there is "a problem." As researchers and mental health professions, we can ill afford to continue to deny the fact that negative practices with reference to minorities exists. While there is indeed a role to play on the part of minorities (e.g., voicing problems resulting from disaster and seeking help), the bulk of the responsibility is on the part of the mental health professional. After all, our mission is to assist and help those who fall prey to

the vicissitudes of natural and technological disasters. Knowing that “avoidance” is the classic response to trauma, buttressed by the many challenges and obstacles facing People of Color, the time for creativity and true commitment is NOW!

Third, it is paramount that the reader recognizes that maximal participation of minority and marginalized groups in research efforts will be forthcoming in instances where meaningful relationships have been forged and are operative prior to the event. No matter how rudimentary or firmly established these relationships might be, their presence is essential to ensure success in times of crisis. During and shortly following disastrous events, individuals are most likely to turn to trusted and enduring support systems where previous successes have been demonstrated. Whenever anyone asks members of our team the question: “What is the key ingredient in gaining access to individuals following disasters?” We give the same three-word answer: “relationship, relationship, relationship.” We believe that an important prerequisite for any type of meaningful entry into families or communities is the development of relationships. What follows is a brief description of a model that is producing meaningful benefits for minority groups. While its context is “Prevention of Youth Violence,” rather than disaster, its application to disaster should be readily apparent.

This conceptual framework for the National Academic Centers of Excellence for Youth Violence Prevention (ACE) designed to enhance the mental and/or physical health of individuals affected by violence, offers the following suggestions. First, the establishment of a participatory process consisting of diverse local, state, and national stakeholders was recommended. The requirement of having the “key players of color” at the table during the early planning phases of projects is imperative and is also an

important element of the cultural competence model. Secondly, the requirements of relationship building and careful planning are also key components of this model and are essential prerequisites for successful ventures with minority communities.

Another essential component of this model is “build capacity.” Requiring researchers to work hand in hand with a variety of individuals within a given community, ranging from laypersons to professionals is a major component for “relationship building.” For example, from the initial stages of forming consensus on “the plan of action,” to the actual obtainment of data following disaster, researchers should openly and consistently solicit input from community partners. The “openness” of the researcher to receive input from the targeted group, at any point in the process, should have an important impact on communities’ acceptance of various aspects of the project. A culturally competence team, sensitive to the unique needs of a given community, should play a major role in the training, mentoring and provision of technical assistance to community participants. Once the data are collected and analyzed, input from these “community partners” in the interpretation of findings as well as their translation into practice and policy should be obtained.

Given that cultural sensitivity is a sine qua non of these types of efforts, a second example is in order. Israel, Schulz, Parker, & Becker (1998) describe a collaborative approach to community-based research in which studies are conducted in community settings utilizing input and active participation of actual community members in the research process. Israel et al (1998) cite multiple features and benefits to community-based research approaches. These research designs build on the strengths and pre-established networks already in place within the community. Additionally, a collaborative partnership is facilitated between researchers and community

members, thereby increasing ownership and control of the studies being conducted. Another benefit of community-based research designs is that they involve partnerships of individuals with a diverse array of skills. This wide selection of different skills is often quite valuable at solving the complex problems addressed by community-based research designs. When formed and implemented correctly, collaborative community-based research designs can be an effective way to work with individuals in minority and marginalized communities.

ACCESS

First of all, a number of very practical suggestions are provided in Appendix A. Readily adaptable strategies targeting a variety of practical issues include: using publicity campaigns to recruit participants, use of door to door recruitment, and providing transportation to research sites as well as incentives for participation. An additional course of action is the use of educational efforts to enhance potential participants' involvement in the research study. Information regarding the research process, as well as the relative benefits of data collection to community members is a vital step in gaining access to these communities. Such information may also serve to lessen the impact of stigma toward "mental health." Stigma associated with "seeing a psychologist or psychiatrists" has served as a major obstacle in some minority communities. In my role as a clinician as well as a researcher, I am all too familiar with the negative impact of this phenomenon. The need for individuals to become aware of the relative merits of sharing their

experiences during the disaster as well as their resulting fears and needs (both psychological physical), is of vital importance. Both the recovery, on the part of survivors, and knowledge to be gained by the research can be facilitated.

While our model provides no solution for the lack of insurance, it suggests that in addition to incentives, forms of assistance such as the provisions of monies for day care be provided. Regarding racial and ethnic barriers, the use of indigenous professionals, paraprofessional, and community leaders cannot be underestimated in such a venture.

A fairly successful strategy was implemented in our National Institutes of Mental Health (NIMH) funded project designed to assess the impact of residential fire. In light of the fact that AAs are among those most at risk to experience injury and death resulting from fires, access to this was group was essential. Therefore, to gain the acceptance of churches and/or church members we incorporated a “religious component” within our protocol to capture “culturally sanctioned ways of coping.” More specifically, a measure of religious coping was administered where questions pertaining to the role of prayer, attending church, and looking to religious leaders in times of crises were examined. When approaching various religious organizations, we were able to inform them of the inclusion of these questions, with the goal of determining the relative role of such “religious practices” on their recovery. Given that we found this practice to be particularly helpful, we strongly advocate for the inclusion of instruments that tap culturally specific modes of dealing with disasters.

A second illustration follows demonstrating the success of a community-based initiative in lessening barriers to access. This project began at The Lutheran Medical Center in Brooklyn, New York over 30 years ago. Its primary goal was to meet the need for

primary care of underrepresented neighborhoods. It presently embraces a “community-oriented, culturally competent approach” where health is defined in a more holistic fashion. In addition to its ultimate goal of reducing medical illness, the provision of adequate housing, opportunities for employment and education, and civic participation are also targeted. Communities served include Chinese, Mexican, Central and South Americans, Dominicans Russians and Middle Eastern populations.

A unique feature of this entity is that it consists of a network of primary care sites where individuals can gain access for assistance through multiple pathways. These sites consist of a behavioral health care center, school based health care centers, community-sited health education and wellness centers, family support and literacy programs as well as a range of other supportive programs. The extent to which the disaster researcher’s goals overlap with those of members of the community may do much to enhance participation. Addressing the age-old questions of “what’s in it for me?” up front and in a straightforward manner is likely to enhance participation even in the face of historical challenges. For instance, if parents are informed that disasters have been found to interfere with academic performances of “some” children, they may be open to “finding out” how their child’s academic performance might have been affected. Consequently, their willingness to participate might be greatly enhanced. If intervention strategies are promised following assessment, this may be an even greater reinforcer for those whose children might benefit.

In communities where such elaborate cultural competent systems are yet to be established, a similar approach can be taken whereby disaster studies may be endorsed by, and carried out in, culturally sanctioned entities. For example, in several investigations design to assess the impact of fire-related trauma on children and their families, we found a great resource within the “culture of the

Red Cross.” That is, after informing Red Cross officials of our work and its potential to develop a “knowledge base” regarding the psychosocial impact of disaster on families, they not only embraced several of our projects, but also provided actual sites where we were able to recruit participants and actually carry out interviews. The essential point here is that conceptualizing existing “cultures” as resources can provide another means of gaining access to minorities communities. We should add that this strategy is particularly applicable to situations where previously established “has not” relationships were developed. The leveraging of existing entities within communities may be the most effective route to pursue.

CULTURE/LINQUISTICS

Please refer to Appendix A where a list of suggestions is provided to address issues related culture/linguistic challenges. A major initiative established to deal with challenges of non-English speaking individuals is entitled: National Standards for Culturally and Linguistically Appropriate Services in Health Care (U.S. Department of Health and Human Services, 2001b). The U.S. Department of Health and Human Services’ (HHS) Office of Minority Health (OMH) established a set of fourteen standards “to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.” (U.S. Department of Health and Human Services, 2001c, p. 1). The major goal of these standards is to “correct inequities that currently exist in the provision of health services and to make these services more responsive to

the individual needs of all patients/consumers.” (p.1). Gleaning from the standards proposed, we feel that the following recommendations would aid the disaster researcher interfacing with minority communities.

1. Ensure that all participants receive effective, understandable, and respectful care provided in a manner that compatible with one’s culture health beliefs and practices, and preferred language.
2. The inclusion, retention, and promotion of individual representatives of the traumatized community on the research team.
3. Research teams should ensure that all members receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Research teams must offer and provide language assistance capabilities, including bilingual members and interpreter services to all participants with limited English proficiency, at no cost.
5. Research teams and labs should develop and implement a written strategic plan outlining goals, policies, and systems of accountability to engage culturally and linguistically appropriate services. Such activities should be routinely assessed.
6. Inclusion of culturally and linguistically competent measures should be required by all teams as well as assessments of participants’ satisfaction with such measures

7. Collaborative partnerships with traumatized communities should be established where individuals representative of these communities are involved in the designing and implementing of research based initiatives.

In summary, if research participants of color are to be ensured culturally and linguistically appropriate treatment, it is incumbent upon the research team to systematically implement the above recommendations. Essentially, when participants are not comfortable with the English language, other means of appropriate translation should be explored (Vijver & Leung, 1997). Furthermore, interviewers need to understand the meaning of body language, gestures, postures and inflections within minority group as to enhance the overall effectiveness of the interview process.

One final point that needs to be addressed by researchers relates to the question: “Should a proactive research agenda be used, or questions rose by community representatives?” As physicists tell us, light is made up of both waves and particles. It is not an “either/or” issue. So too is the case here. We feel that proactive research agendas should be designed based on current science and best practices guidelines. However, there should be ample flexibility within this agenda to accommodate questions that are perceived by community members as vital. In order to obtain “maximum buy-in” it is essential that this type of “give and take,” is afforded.

SUMMARY

We conclude that challenges of minorities and other marginalized communities including; the gross under representation of disaster research studies targeting these groups, the mistrust on the part of minorities toward researchers as well as the mental health

system, the lack of access afforded minorities during and following disaster, and the cultural and linguistic challenges are best addressed through the adoption of attitudes, behaviors and processes embraced by culturally competent approaches.

The benefits of a culturally competent framework on the part of the trauma researcher are enormous. The wealth of resources resulting from relationship building, engagement of indigenous professionals, paraprofessionals and community leaders, sensitivity in the training, mentoring and provision of technical assistance to participants and “openness” of the researcher to receive input from community are certain to enhance the quantity and quality of interaction between the traumatized communities and researchers. It is hoped that this union will do much to not only enhance our knowledge of the impact of disasters on these groups, but also more importantly enable mental health professionals to better assist during the recovery process following disaster.

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Appendix A

Mistrust/Beliefs

| |
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| Assess & discuss levels of mistrust |
| Find community gatekeepers and request their involvement |
| Interact with leaders & members of target community |
| Build rapport by establishing bonds with members of the community |
| Include representatives from the target groups as part of the research team |
| Use People of Color and individuals from marginalized communities as role models |
| Understand current needs & realities of target group |
| Recognize and respect differing cultural beliefs and practices |
| Recognize the importance of churches and other community organizations as Legitimate support systems |
| Contact people personally when possible |
| Articulate the fact that the program will benefit the target group |
| Demonstrate how the benefits will outweigh risks |
| Ensure research will be conducted ethically |
| Assure all data are confidential & will be used for research only |
| Use culturally sensitive instruments |

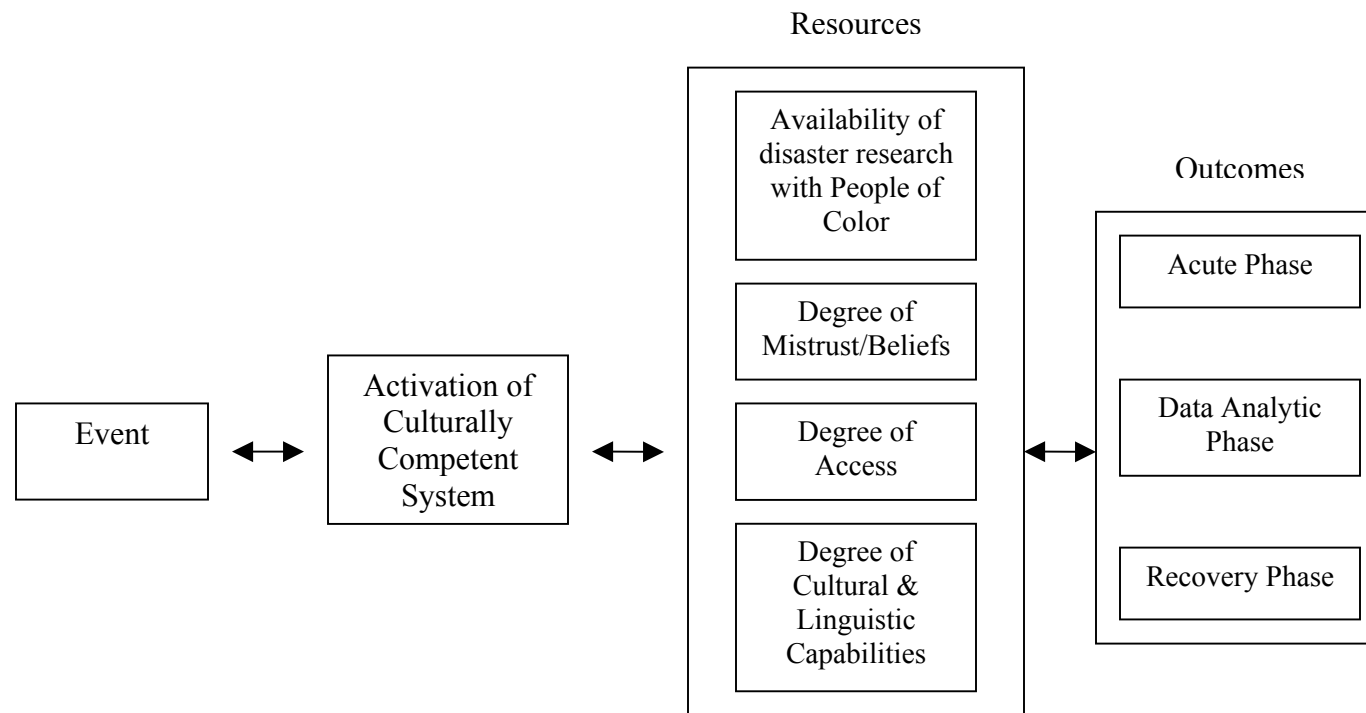
Barriers to Access

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|--|
| Find study sites proximate to communities/convenient location |
| Use publicity campaigns directed at minorities |
| Use door-to-door subject recruitment |
| Develop convenient hours of operation |
| Provide/find transportation services to research/treatment sites or reimbursement for transportation costs |
| Provide financial assistance, fee waivers, & incentives |

Culture/Linguistics

| |
|---|
| Development, implementation, and assessment of specific plans that outline goals, policies, and systems of accountability when engaging in culturally and linguistically appropriate services |
| Ongoing training of all research team members in culturally and linguistically appropriate service delivery |
| Appropriate translation or interpretation of research materials and measures when research participants are not comfortable with the English language |

Figure 1



CULTURAL COMPETENCE MODEL FOR ACCESSING MINORITY AND MARGINALIZED COMMUNITIES IMPACTED BY DISASTER