Cultural Considerations:

Working with Diverse Communities in a Disaster and Applications to Tele-mental Health Services

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In the current impact of the COVID-19 crisis, there have been many resources available to assist with mental health providers' quick transition to tele-health services and providing care and support to our communities.

As ethical providers, we cannot forget our dedication and responsibility to the provision of culturally competent care, which may be unique in this situation.

Those at greater risk for developing adverse reactions after a disaster include those of female gender, ethnic minority groups, poverty or low SES groups, those with prior exposures to highly stressful experiences, individuals age 40-60, those over age 65 who are sick, economically disadvantaged, frail, or those impacted by evacuation procedures, and those facing post-event adversities (*Risk and Resilience Factors After Disaster and Mass Violence - PTSD*, 2019).

Below you will find a collection of information (though not by any means comprehensive information) regarding:

1. Considerations and recommendations for working with diverse populations during this time of international crisis.

2. Cultural considerations when providing tele-mental health services.

3. List of resources and references that may be useful with more in depth information regarding these issues

Cultural Considerations in a Disaster

Why is this important?

Beyond our responsibility as ethical providers, research has shown that ethnic minorities (e.g., African Americans, Asian Americans, Native Americans, Latinos) may suffer from more adverse consequences after disasters than white Americans (Norris & Alegria, 2005).

During a time of crisis and quick transition to tele-mental health platforms, there are many reasons why nonabaondonment of ethnically diverse patients is particularly important (Brooks et al., 2013).

- Alaska Native, American Indian, and African-American populations have experienced various levels of abuse or apathy in governmental programs and have reported feeling disenfranchised or disinterested in pursuing treatment from outside sources.

- Rural communities have witnessed the "revolving door" of short-term medical practitioners in their area and this may be hesitant to engage in services that they fear will not be available in the long term.

- Many ethnic minority populations may experience stigmas around mental health care or have beliefs that their condition is somehow fated or a part of "God's will" and are not deserving of mental health treatment.

Despite the heightened risk for adverse consequences, there are cultural factors that may be *beneficial* to minorities in the face of a wide-spread disaster.

Help Seeking:

Research has shown that overall, minorities held more positive views about seeking help from other people and this effect was more pronounced for outsiders (Kaniasty & Norris, 2000).

However, that does not specifically address willingness to acknowledge mental health struggles and seeking professional help. They may prefer to receive help from natural, informal sources. Stigma in these communities is also a large barrier (Norris & Alegria, 2005).

This suggests it may be beneficial offer more psychological first aid or outreach to those communities, rather than deeper psychotherapy in the immediate aftermath of a disaster. Successful programs that have done significant amounts of outreach and provide a familiar and welcoming atmosphere have shown positive impacts on minority survivors of disasters. Preliminary data from Project Liberty (Felton, 2002) in New York's aftermath of 9/11 suggests that minorities are as likely as others to seek and receive care when other barriers are reduced (stigma, mistrust) or eliminated (cost; Norris & Alegria, 2005).

Recommendations from crisis counseling programs can also address these issues (Norris & Alegria, 2005):

- Disaster survivors are normal people responding normally to abnormal situations. Therefore, services should be directed at normalizing individuals' experience and distress. By normalizing distress and help seeking, disaster services have the unique opportunity to destigmatize mental health care.

- People prefer natural sources of assistance and therefore those services should be provided in schools, churches, and places of work.

- People who need help the most may not necessarily seek it. Service providers must be proactive to reach out to vulnerable groups.

Collectivistic Cultures:

Many American minority groups may embrace cultural values of collectivism, social connectedness, assisting their communities, etc.

Community-based mental health care that addresses social engagement and assists survivors with their social functioning may be a good fit with the cultural values and needs of many American minority groups (Norris & Alegria, 2005).

- In collectivistic cultures that emphasize interdependence, an important aim would be the promotion and support of adaptive and harmonious social relationships. "Perceptions of belonging and being cared for are critical to the well-being of disaster victims" (p. 137).

- It is important to note that disaster survivors who have fewer economic resources or are members of ethnic minority groups often receive less social support than those who hold more privilege. Socially and economically disadvantaged groups are frequently too overburdened to provide ample help to other members in time of additional need, thus gaps in minorities social support networks may emerge.

Culturally based rituals and traditions sometimes can be used as the basis for innovative interventions.

Recommendations for Working with Diverse Individuals during a Disaster:

"Always remember that the individual is embedded in a broader familial, interpersonal, and social context. The interventionist or practitioner must spend time assessing and addressing socially relevant cognitions, emotions, and roles. This includes constructs such as perceptions of social support, social competence, belonging, and trust; mutuality and marital satisfaction; social participation, sense of community, and communal mastery; withdrawal, loneliness, isolation, interpersonal estrangement, shame, and remorse; familial obligations, caretaking burdens, and parenting stress; domestic and other interpersonal conflicts; and hostility, anger, societal alienation, perceptions of neglect, and acculturative stress" (Norris & Alegria, 2005, p. 137.)

The following recommendations for working with ethnic minorities post-disaster have been derived from *Ethnocultural Perspective on Disaster and Trauma: Foundations, Issues, and Applications* (Marsella et al., 2008). This book provides more considerations for working with specific groups.

- "**Assess community needs early and often**.
  Prior research indicates that minorities are at elevated risk for post-disaster mental health problems such as depression and PTSD. Small but important percentages will have mental health needs that predate the disaster. Assessment of needs in disaster-stricken communities is critical, and these assessments should oversample minority populations to determine the ways in which they were exposed and affected by the particular event. Because diagnoses may be less valid for minority persons and because they represent only the tip of the iceberg in any case, needs assessments should include a focus on experienced emotional distress and impaired functioning, especially social functioning. Valid needs assessments for culturally diverse populations also require information on contextual and cultural variables such as trauma exposure in the country of origin, losing of social ties, level of comfort in host society, and level of English-language proficiency. Gaining support among policy researchers is the notion of surveillance. Needs evolve. Repeating the needs assessment periodically will provide invaluable information about the extent to which minorities are recovering from the disaster, have recovered, or still require help. Gaps in rates of recovery, awareness of services, and use of services can be noted and addressed.

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

- **Work collaboratively and proactively to reduce stigma and mistrust and to engage minorities in care**.
  It should be anticipated at the outset that minority disaster victims, even those who have suffered intensely, will not necessarily seek professional mental health services, as they will tend to rely on families, friends, and other natural sources of help. Viewing this as an asset rather than a problem to be overcome reminds the interventionist to work collaboratively with natural helpers in the community, such as promotor as or paraprofessionals with experience and credibility in the community. To reduce disparities in service use, programs must build trust and be highly proactive; practitioners must get out of the clinic into the community. To the extent possible, programs should employ ethnic minority practitioners in the recruitment, retention in care, and recovery efforts. If such practitioners are scarce, they may serve the overall effort best in consultant, training, and supervisory roles. Local representatives of minority communities should be involved from the outset in preparing for and planning responses to disasters and terrorism.

- **Validate and normalize distress**.
  Over and over again, experienced disaster and trauma clinicians emphasize that some distress is a normal reaction to an abnormal event. But this does not mean that help cannot lessen that distress or hasten recovery. Help seeking as well as symptoms can and should be normalized. Diagnosis of pathology should be deemphasized, relative to standard practice. Even when highly stressed, most people possess strengths they can draw on, and an important task of the clinician is to help individuals identify and mobilize their natural resources. At the same time, education regarding when dependence solely on self reliance can be harmful to overcoming one's mental health problems or emotional distress should also be a task of disaster service providers. Self-reliance ("can handle the problem on my own'') is a strong barrier to mental health care (Ortega & Alegría, 2002).

- **Value interdependence as well as independence as an appropriate goal**.
  As noted previously, the individual is embedded in a broader familial, interpersonal, and social context. The practitioner must spend time assessing and addressing socially relevant cognitions and emotions. The intervention goal is to enhance social functioning, helping the person retain or resume his or her social roles.

- **Promote community action**.
  Novel and innovative strategies should be explored that involve minority communities in their own recovery by working toward specific, achievable goals. Social marketing, advocacy, community organizing, train-the-trainer models, and mentoring programs are but a few examples that can be explored. By assuming a consultant or facilitator role, practitioners can help communities make informed choices while still recognizing that the choices are the community's own. At the same time, finding out about successful community interventions with similar communities and populations might help identify ingredients that can be used to enhance mainstream interventions.

- **Recognize that cultural competence is a process not an end-state**.
  Clinicians will only experience despair if they are expected to know everything that would be helpful about every culture that makes up the American whole. The importance of continuing education cannot be overstated.

- **Advocate for, facilitate, or conduct treatment and evaluation research.**
  There are still so few data on which to base recommendations for culturally responsive mental health care. Minorities will ultimately be better served if practitioners and researchers collaborate to test the efficacy and effectiveness of different intervention strategies.

- **Leave a legacy**.
  Notwithstanding the pain and stress they cause, disasters create opportunities to educate the public about trauma and mental health, to destigmatize mental health problems and mental health services, to build trust between service providers and minority communities, and to develop collaborative relationships that may serve the entire populace for years to come" (p. 28-31).

Adapting Culturally Appropriate Care to Tele-mental Health Practice

Individual background has a strong contextual influence on whether and how technology is used and thus the interplay of tele-mental health and culture should be considered.

Technological Considerations when Working with Diverse Populations (Brooks et al., 2013)

- **Verbal Communication**.
  Cultures vary in their use of verbal communications in respect to the use of silence, the pace of the dialogue, and the tone of the conversation. Silence is an especially important aspect to be aware of. Be cautious not to overuse pauses or mistakenly attribute patients' silence to anything other than their reaction to the technology. Consider having overt conversations about how silence, conversational tone, pace, interruptions, etc. may occur differently when using tele-health and process these differences.

- **Nonverbal Communication**.
  Nonverbal cues vary widely in many cultures including eye-contact, facial expressions, etc. Be aware of how your image is projected to the client. Be aware of the clothing you're wearing, even if you're not technically leaving your home.

- **Symbolism**.
  Many cultures identify with specific symbols, objects, and designs, and the use of these items can help put patients at ease in a clinical setting. Be aware of the potential symbolism or person objects that exist within the camera's view.

- **Technological Knowledge and Comfort.**
  When orienting new patients to tele-mental health, clinicians should directly ask about the clients' prior experience with computers, videoconferencing, or other electronic devices. It is important to explain how the technology will be used and to assure patients of the privacy and confidentiality, as many individuals are often wary about what will be seen by whom. For patients who have little prior experience with telehealth, their comfort level typically improves as they gain more exposure to the technology.

Older Adults: Tele-mental Health Services Considerations

Recommendations

Sheeran et al., (2013) provide recommendations for improving communication and outcomes when a videoconferencing approach is used for elders, based on the authors' *anecdotal* experience using tele-mental health options in nursing home.

- **"Do not underestimate elders' acceptance.**

We observed that many elders not only understood the reasons for using a tele-mental health rather than a face-to-face approach, they actually appreciated the use of the technology. They asked questions about its effectiveness versus face-to-face consultations, were interested in the instrumentation and how it worked, and appreciated that we spent the time and money to make a videoconference possible. Some of our patients had careers in fields related to telecommunication and were particularly interested in and accepting of our methods.

- **Make family participation the rule rather than the exception.**
  We found that family member "buy-in" of our approach was extremely important. They provided helpful background and baseline information, encouraged their loved ones to participate in the videoconference, acted as "surrogate staff" by repeating or restating our questions for patients with hearing or vision impairment, and they helped to explain the technology to patients who were apprehensive or who, because of cognitive impairment, could not fully appreciate the approach.

- **Allow patients and families to use the equipment.**
  We always have remote control of the distant site's camera. For interested patients or families, we have briefly enabled their remote control over our camera, allowing them the opportunity to "drive" the camera, to see how this technology is used and to feel more comfortable with it.

- **Respect and support nursing-home staff.**
  We could not perform our consultations without the help of nurses, social workers, and other staff members. There is always a nurse present at the distant site: we meet with her/him before each patient encounter to obtain a new or updated history and to discuss what options might be likely once the visit is completed. We also meet after each encounter to firm up a treatment plan. In addition, the nurse helps with patient positioning, orientation, and "anxiety attenuation," the latter by being a familiar, caring, and competent person, well known to the patient, who can help to allay fears about the new face or faces on the television. The nurse will leave the room if requested or if appropriate to allow some private time for the patient and psychiatrist" (p. 186)

In addition to these recommendations, Sheeran et al. (2013) suggest that for individuals with hearing impairments, amplified headphones may be beneficial. With vision impairments, ensure that illumination and contrast on their monitors are sufficient.

People with Disabilities: Tele-mental Health Considerations

"People with disabilities, especially women and people of color, experience significant mental health disparities compared to people without disabilities due to programmatic, sociocultural, economic and physical barriers" (*APA Tip Sheet for Telehealth and Persons with Disabilities*)

They also more frequently have less access to the internet and those that do tend to have slower connections. People with disabilities report owning fewer cell phones or similar devices.

Recommendations for providing tele-mental health services to individuals with disabilities (derived from the American Psychological Associations' Tip Sheet for Telehealth and Persons with Disabilities, available online)

- "Assess the individual's needs as well as the benefits and risks of using technology to provide services.
- Consider the products, services and environmental factors that are required to provide effective telehealth services to the consumer.
- Become aware of existing barriers for the individual with disability. Work to remove these barriers.
- Consider the compatibility of phones, equipment and computer-based programs used by the consumer and whether the products can work effectively with your method of service delivery.
- When using home-based or consumer technology, be mindful of the needs of your consumer regarding website accessibility, captioning and assistive technology and equipment.
- Learn about accessibility features and functions on software programs and apps that you might use.
- If services are provided via a telehealth center, be mindful of the needs of your consumers (e.g., access for wheelchairs and power-driven mobility devices, service animals, use of video relay interpreters, use of assistive technology and equipment).
- Work with an assistive (adaptive) technology professional or rehabilitation engineer if necessary.
- Be mindful that some individuals with disability work closely with a family member, caregiver and/or home health care provider. What is the role of this person, if any, in the consumer's treatment? Consider the potential impact this may have on the provision of services.
- Develop a specific plan with the consumer that addresses emergency and/or unusual situations. If an emergency arises, ensure that the consumer knows of a local hospital, clinic, and/or professional equipped to provide them the appropriate support or care.
- Increase awareness and skills related to cultural competency and linguistic sensitivity.
- Working with an individual with a disability? Unsure about their needs? Just ask."

Special Considerations when providing tele-mental health services to deaf individuals (Wilson & Schild, 2014)

Deaf individuals are frequently exposed to video conference technology and, as a result, may already have higher confidence and comfort levels with the equipment and technology.

The mainstream population may not be aware of the fact that qualified Deaf individuals in the United States are eligible to receive free, specially dedicated videophone equipment.

Within the Deaf community, the video conferencing technology is commonly referred to as a videophone, which has been a common and integral part of the U.S. Deaf community for over 10 years.

With this technology, a Deaf individual may call an ASL interpreter using the videophone's integrated video relay services. An ASL interpreter (or relay operator) will appear on the Deaf individual's screen and assist in facilitating communication between the Deaf and hearing person.

Another service that can be used with videophone technology is video remote interpreting services.

Video remote interpreting services allow for an ASL interpreter to be provided in areas where in-person accommodations may not be available.

More Resources

The following resources may assist in culturally competent mental health service in the aftermath of a disaster. This is not a comprehensive list by any means.

Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations – U.S. Department of Health and Human Services
https://store.samhsa.gov/system/files/sma03-3828.pdf

Psychosocial Issues for Children and Adolescents in Disasters - U.S. Department of Health and Human Services
https://store.samhsa.gov/system/files/adm86-1070r.pdf
https://www.youtube.com/watch?v=bsaImMbgkh8&list=PLBXgZMI_zqfRcTt9ndxkbieQ-pQslk-R6

Tips for Disaster Responders: Cultural Awareness When Working In Indian Country Post Disaster– Substance Abuse and Mental Health Services Administration (SAMHSA)
https://store.samhsa.gov/system/files/sma14-4867.pdf

Tip Sheet: Telehealth and Persons with Disabilities: What Psychologists Should Know – American Psychological Association
https://www.apa.org/pi/disability/resources/publications/newsletter/2013/05/telehealth-psychologists

Guide addressing Social Stigma associated with COVID-19 – UNICEF
https://www.unicef.org/documents/social-stigma-associated-coronavirus-disease-covid-19

Older Adults:

SAMSHA Post-Disaster Behavioral Health Resources for Older Adults
https://www.samhsa.gov/dbhis-collections/older-adults?term=Older-Adults-DBHIS

Older people in disasters and humanitarian crises: Guidelines for best practice – United Nations High Commissioner for Refugees
https://reliefweb.int/sites/reliefweb.int/files/resources/1B8B70825D1CC03EC1256C25002856A2-HelpAge_olderpeople.pdf

Psychosocial Issues for Older Adults in Disasters
https://store.samhsa.gov/system/files/sma11-disaster-03.pdf

Stay In Touch in Crisis Situations – A Resource for Older Adults, Administration on Aging U.S. Department of Health and Human Services
https://www.n4a.org/files/InTouch.pdf

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Marsella, A. J., Johnson, J. L., & Watson, P. (2008). *Ethnocultural perspectives on disaster and trauma: Foundations, issues, and applications*. Springer Science + Business Media. https://doi.org/10.1007/978-0-387-73285-5

Norris, F. H., & Alegria, M. (2005). Mental health care for ethnic minority individuals and communities in the aftermath of disasters and mass violence. *CNS Spectrums, 10*(2), 132–140. https://doi.org/10.1017/s1092852900019477

Risk and Resilience Factors After Disaster and Mass Violence - PTSD: National Center for PTSD. (2019, October 14). [General Information]. https://www.ptsd.va.gov/professional/treat/type/disaster_risk_resilience.asp

Sheeran, T., Dealy, J., & Rabinowitz, T. (2013). Geriatric Telemental Health. In C. L. Myers & C. L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice* (pp. 171–195). Elsevier.

Tip Sheet: Telehealth and Persons with Disabilities: What Psychologists Should Know. (n.d.). Https://Www.Apa.Org. Retrieved March 20, 2020, from https://www.apa.org/pi/disability/resources/publications/newsletter/2013/05/telehealth-psychologists

Wilson, J. A. B., & Schild, S. (2014). Provision of mental health care services to deaf individuals using telehealth. *Professional Psychology: Research and Practice*, *45*(5), 324–331. https://doi.org/10.1037/a0036811