

Asian American Mental Health:

A Post-September 11th Needs Assessment

**Asian American Federation of New York
September 2003**

Copyright © 2003 by Asian American Federation of New York



Support for this publication was provided by two grants from The Robert Wood Johnson Foundation in Princeton, New Jersey

Foreword

The second anniversary of September 11th finds New York City further along in its recovery from the events of that date, poised in a stage of both memory and renewal. The last two years have given our city, our nation and the world an opportunity to absorb and reflect upon the tragedy's myriad meanings and its societal and global consequences. Cadences of renewal resonate externally, with the progression of plans for rebuilding the World Trade Center site, efforts by various constituencies to revitalize the crippled regional economy, and restoration of other physical resources lost in the disaster's wake.

However, for individuals directly affected by the loss of a loved one or other emotionally traumatic experiences connected to September 11th, the personal recovery process can be obscured from the outside. The painful processes of grieving over a loss and rebuilding or moving on with a life that was instantly and deeply transformed can be an isolated experience – one that is not easily comprehended by or shared with others. For Asian Americans, this is especially true.

As described in this report, in times of distress, Asian cultural values of self-reliance, reservation and non-expression typically prompt individuals to avoid seeking assistance in dealing with emotional issues. The concept of therapy is alien to many Asian immigrants. Meanwhile, there are not enough community resources to cultivate and sustain linkages between the many Asian Americans in the New York City area who need emotional help and mental health professionals who can provide it in a way that is culturally and linguistically effective and relevant to these individuals.

The Federation undertook this study to shed light on the extent and nature of emotional trauma among Asian Americans affected by the September 11th tragedy and to examine how these individuals have coped with psychological repercussions. A key factor influencing this research project was the Federation's commitment to ensuring that consideration of Asian American needs and recognition of the gaps in services for these populations are considered in dialogues and decisions about post-September 11th mental health intervention approaches and resource allocations.

This report provides a comprehensive knowledge base about the mental health status and needs of two uniquely and severely impacted Asian American communities: World Trade Center victims' families and vulnerable populations in Chinatown, specifically children, the elderly, and unemployed workers. A compilation of quantitative and qualitative research, the report represents the first broad-scale documentation and analysis of mental health issues among Asian Americans in the New York City area.

The Federation extends its deepest appreciation to the Robert Wood Johnson Foundation, without the generous support of which this study would not have been possible. We would especially like to recognize the invaluable help of Ms. Jean Lim, former Program Associate, Dwayne Proctor, PhD, Senior Communications Officer, and James Knickman, PhD, Vice President for Evaluation and Research, at Robert Wood Johnson Foundation in this endeavor. We would also like to give special recognition to the Project Liberty program at Hamilton-Madison House for contributing a large amount of administrative information and valuable staff resources to this project. In addition, the Mental Health Association of New York City/Asian LifeNet and the American Red Cross of Greater New York deserve our gratitude for sharing important data and staff time. The Federation also acknowledges the large number of mental health and social service professionals in the community who supplied information for this study. Furthermore, we would like to recognize the valuable insight and guidance of our research study advisory board, composed of mental health experts from academia and the community. The Federation also thanks its talented research team for its truly committed efforts in conducting a challenging study whose results will serve as an illuminating guide toward full post-September 11th recovery. And, finally, we offer our sincere gratitude to the World Trade Center victims' families and the people of Chinatown who provided a unique glimpse into their lives, sharing their own deeply personal and moving stories.

Mental health is a long-term issue. At the second anniversary of September 11th, the Federation recognizes the need for sustained attention to the psychological recovery of New York-area Asian Americans. This report reveals that large portions of our communities are suffering silently, and it asserts that for genuine healing to occur, Asian American mental health issues need to be addressed actively, in ways that are effective and culturally appropriate.

Cao K. O
Executive Director
Asian American Federation of New York

RESEARCH ADVISORY COMMITTEE*

Rhea Almeida, L.C.S.W., Ph.D.
Executive Director, Institute for Family Services

Teddy Chen, D.S.W.
Co-Director, Charles B. Wang Community Health Center, Mental Health Bridge Program

Freda Cheung, Ph.D.
Associate Professor, Research Center on the Psychobiology of Ethnicity,
Harbor-UCLA Medical Center

James Chou, M.D.
Research Associate Professor of Psychiatry, New York University School of Medicine
Research Psychiatrist, Nathan Kline Institute

Benjamin Chu, M.D.
President, New York City Health and Hospitals Corporation

Henry Chung, M.D.
Medical Director, Pfizer, Inc.
Clinical Associate Professor of Psychiatry, New York University School of Medicine

Jane Eng, Esq.
Executive Director, Charles B. Wang Community Health Center

Rajiv Gulati, M.D.
Psychiatrist, New York University School of Medicine

Abdulla Hasan, M.D.
Director, Bellevue Hospital Center - South Asian Clinic

Chol Lee, M.D.
Director, St. Vincent's Catholic Medical Center - Psychiatric Inpatient Unit

Kin Wah Lee, M.P.A.
Former President, New York Coalition for Asian American Mental Health
Director of Quality Assurance, Kingsboro Psychiatric Center,
New York State Office of Mental Health

Larry Lee, M.S.W., M.A.
Associate Commissioner, Child Care and Head Start, Administration for Children's Services

Gisela Lin, Ph.D.
Psychologist and Coordinator, Texas A&M University, Student Counseling Service

Paul M. Ong, Ph.D.
Professor, Graduate School of Public Policy and Social Research
Director, The Ralph and Goldy Lewis Center for Regional Policy Studies
University of California, Los Angeles

Angela Shen Ryan, Ph.D.
Professor Emeritus, Hunter College School of Social Work

Tazuko Shibusawa, Ph.D.
Assistant Professor, Columbia University School of Social Work

Derald Sue, Ph.D.
Professor of Psychology and Education, Columbia University Teachers College

Stanley Sue, Ph.D.
Professor, Psychology & Psychiatry
Director, Asian American Studies Program
University of California Davis

David Takeuchi, Ph.D.,
Professor and Associate Dean of Research, University of Washington School of Social Work

Peter Yee, M.S.W.,
President, New York Coalition for Asian American Mental Health
Assistant Executive Director, Hamilton-Madison House

Marianne Yoshioka, Ph.D.
Assistant Professor, Columbia University School of Social Work

**** The views expressed in this report are those of the Asian American Federation and do not necessarily reflect the views or positions of the research advisory committee.***

RESEARCH TEAM

Project Director:

Shao-Chee Sim, Ph.D., Former Director of Research, Asian American Federation of New York¹

Principal Investigators:

Carol Peng, M.S.W., Assistant Director of Research, Asian American Federation of New York

Irene Chung, Ph.D., Assistant Professor of Social Work, Hunter College School of Social Work

Arpana Inman, Ph.D., Assistant Professor, Counseling Psychology Program,
Department of Education and Human Services, Lehigh University

Christine Yeh, Ph.D., Assistant Professor of Psychology and Education,
Department of Counseling and Clinical Psychology, Columbia University, Teachers College

Research Team Members:

Anna Lee, Research Assistant, Asian American Federation of New York

Pamela Yew Schwartz, Ph.D., Psychologist, Manhattan Psychiatric Center

Meghan Clark, Research Associate, Asian American Federation of New York

Angela Kim, Ed.M., Columbia University, Teachers College

Anvita Madan-Bahel, M.A., Columbia University, Teachers College

Shivani Nath, M.S., MFT, Seton Hall University

Yuki Okubo, Ed.M., Columbia University, Teachers College

Edna Chung, M.P.H., Research Associate, Asian American Federation of New York

Andrew Yan, M.A., Census Information Center Data Manager, Asian American Federation of
New York

¹ Since June 2003, Dr. Sim has been employed by the Wallace Foundation as an Evaluation Officer.

TABLE OF CONTENTS

	PAGE
I. Executive Summary	7
II. Introduction	14
III. Chapter One: The Mental Health Impact of September 11th on Asian Victims' Families	19
A. World Trade Center Asian Victims: Demographic Profile	20
B. Study Participants: Demographic Profile	20
C. Study Participants: Interview Findings	24
D. Quantitative Findings: Project Liberty Data	28
IV. Chapter Two: The Mental Health Impact of September 11th on Chinatown	32
A. Chinatown Neighborhood: Demographic Profile	34
B. Focus Groups: Children, Elderly, and Dislocated Workers	35
C. Prevalence of Mental Health Issues in the Community	41
D. Quantitative Findings: Project Liberty Data	42
V. Chapter Three: September 11th- Related Mental Health Initiatives, Service Utilization, Unmet Needs, and Service Gaps	50
A. September 11 th - Related Mental Health Support	51
B. Service Utilization of Victims' Families	55
C. Service Utilization of Chinatown Vulnerable Populations	57
D. Summary of Service Utilization	60
E. Summary of Findings: Expressed Unmet Needs and Service Gaps	61
VI. Chapter Four: Public Policy Recommendations	65
Appendices:	
A. Methodological Approaches	70
B. September 11 th - Related Mental Health Initiatives	79
C. Program Capacity of Chinatown Community Based Organizations and Other Asian Services Programs in Manhattan	89
D. Demographic and Community Profiles	92
E. Bibliography	104
F. Project Liberty Expressed Event Reactions	107
Acknowledgements	112
About the Asian American Federation of New York	116

I. Executive Summary

September 11th permanently and profoundly altered the lives of communities across the New York City metropolitan area. The nature and magnitude of the tragedy engendered losses of unprecedented scope and depth. For the general public, the pervasiveness of emotional impacts has raised the level of consciousness about mental health issues and widened acceptance of help-seeking to a degree. However, for the Asian American community, which historically has faced a host of unique barriers to mental health care, mental health service usage has remained virtually unchanged.

This report documents the post-September 11th mental health status, service use and unmet needs of two impacted groups: 1) family members of World Trade Center victims of Asian descent and 2) vulnerable populations in Manhattan's Chinatown. The report offers a window to deeper understanding of the obstacles to effective mental health care, including the gaps in services, which confront this community. The findings are derived from a variety of qualitative and quantitative sources, including individual and focus group interviews and surveys of affected individuals and mental health and social service providers. Analyses of administrative datasets comprising information about more than 15,000 individuals are also presented.

Based on these findings, public policy recommendations are set forth with the intent of increasing access to mental health services and improving service delivery in a post-September 11th context for the groups studied and other Asian American populations in need.

A. Findings

1. World Trade Center Victims' Family Members

Of the 2,743 documented World Trade Center deaths, 6.7%, or 184, were people of Asian descent. Among these Asian victims, 37% resided in New York City, and 41% resided in New Jersey. People of Indian descent were the largest ethnic group among Asian victims, and nearly half of all Asian victims were South Asian.

Nine months after September 11th, interviews were conducted with survivors of 22 Asian victims. Participants were asked about their experience of loss, particularly how they reacted to and actively coped with the death of their family member. In describing their experiences, other culturally and/or racially-tinged themes of struggles associated with September 11th emerged.

- **Psychological and physical reactions associated with the September 11th tragedy**
 - Based on reported symptoms, the interviewers, who are professional mental health clinicians, assessed every study participant as depressed or mildly depressed.

- Family members of World Trade Center victims experienced a range of psychological reactions to their loss, including denial, anger, hopelessness, and a lack of closure due to the inability to obtain a loved one's remains.
 - Physical symptoms were widespread – a salient finding for a population for whom underlying emotional issues tend to manifest themselves as more culturally acceptable health conditions. Many participants reported sleep problems. South Asians experienced changes in appetite, loss of hair and darkening of skin. Other Asians reported heart palpitations, blood pressure problems, and physical pain.
 - The quantitative analysis of service utilization data from the federally-funded Project Liberty program at Hamilton-Madison House, the largest mental health service provider for Asian Americans in New York City, also revealed high levels of adverse behavioral, cognitive, emotional, and physical responses – all indicating mental distress – among survivors of Asian victims of the World Trade Center attacks.
 - Furthermore, the analysis revealed that, to varying degrees, Asian American victims' families in the sample population assessed by Hamilton-Madison House suffered more negative reactions relative to victims' families in this total sample population.
- **Coping methods**
 - Avoidance and self-distraction were common methods of dealing with the loss.
 - Coping mechanisms for study participants and other family members also included informal contact with relatives and friends, as well as culturally-based alternative healing methods, such as palm reading and astrology.
 - Religion and spirituality played a significant role in the way many participants dealt with their loss.
 - Participants reported very little use of professional mental health services.
- **Other September 11th-related challenges**
 - Many participants cited other difficulties arising from September 11th that intensified the emotional impact and feelings of physical insecurity already engulfing their families.
 - These other issues included increased family responsibilities and perceived racial discrimination on the part of relief organization staff members.
 - In particular, South Asians reported fears and anxieties related to finding themselves targets of racial profiling and hate crimes after September 11th.
 - Another compounding stressor was the family members' loss of legal resident status in the United States upon the death of the victim.

2. Vulnerable Populations in Chinatown

Chinatown's location less than ten blocks from Ground Zero places its community members at heightened risk for negative emotional effects related to September 11th. Some populations are especially vulnerable by virtue of social circumstances and characteristics that tend to limit individual resources, opportunities, and abilities to meet one's own needs and/or sustain quality-of-life independently. Nine months after September 11th, focus groups were conducted with three such populations in Chinatown: children, elderly residents, and unemployed workers. The purpose was to understand the experience of these individuals on and around September 11th, their coping methods, and their mental health status at the time of the study.

- **Demographic Profile of Chinatown**
 - Data from Census 2000 demonstrate that, even before September 11th, low levels of income, citizenship status, English proficiency, and educational attainment already undermined the quality of life of Chinatown's Asian

- population.
- Low socioeconomic status is a major risk factor for negative mental health outcomes. Poverty not only predisposes community residents to more serious economic and social stress, but it also restricts financial, informational and other forms of access to mental health treatment.
- Immigrant status, pervasive among Asians in Chinatown, creates pressures associated with acculturation and assimilation.
- Chinatown was further debilitated by the severe economic and emotional consequences of September 11th. In the first three months after the tragedy, one-quarter of Chinatown's workforce became unemployed as a result of massive business downturns and physical isolation. One year later, the majority of workers in the neighborhood were still experiencing high levels of underemployment.
- **Experience of September 11th**
 - All participants experienced the World Trade Center attacks first-hand or in ways that otherwise fundamentally altered their lives. Experiences such as witnessing the plane crashes; evacuations amidst smoke, dust and debris; an inability to return home right away due to traffic restrictions and police activity; and inability to locate and communicate with family members were common. Most residents of Chinatown lived in isolation because a frozen zone was imposed on the area in the immediate aftermath, and basic electricity and phone services were severed.
- **Mental health impacts on children, elderly, and unemployed workers**
 - Nearly a year after September 11th, the three Chinatown populations studied remained in distress. Shades of trauma manifested themselves in such forms as nightmares among children and insomnia, physical complaints, and fear of leaving home among the adult participants. Unemployed workers also reported heightened family tensions stemming from their job losses.
 - Children expressed fears and concerns about safety; felt anxious due to increased family tension and parental worries about finances; and described an overall sense of loss related to the decline in the quality of their lives after September 11th.
 - Elderly participants complained about post-traumatic stress symptoms; expressed a sense of grief and loss toward the attack on the Twin Towers; and suffered from a sense of hopelessness and helplessness toward their lives and the future.
 - Dislocated workers experienced stress symptoms from the traumatic event, as well as a result of unemployment and related family tensions. Social isolation was universally reported; due to a lack of financial resources, ongoing terrorist threats, and preoccupation with unemployment status, social activities were curtailed.
 - The analysis of Project Liberty data revealed high levels of adverse behavioral, cognitive, emotional and physical responses – all indicating mental distress – among vulnerable populations in Chinatown.
 - Furthermore, the analysis revealed that, to varying degrees, the Chinatown groups in the sample population assessed by Hamilton Madison House suffered more negative reactions in comparison to other Asian Americans in the sample population, and in comparison to the total sample population assessed by Hamilton-Madison House.
- **Coping methods**
 - Despite these lingering effects, no focus group participants reported using mental health services. The elderly tried to avoid emotional issues by keeping

busy with senior center activities. Dislocated workers attended job training classes and did volunteer work. Children generally used the same coping methods as their parents; avoidance and self-distraction.

3. Available Services, Service Utilization, Unmet Needs, Service Gaps

a. September 11th- related mental health initiatives

A number of public and private mental health initiatives emerged after September 11th that have impacts on the Asian American community. These include the American Red Cross and The September 11th Fund, which have partnered to provide mental health and other services. Also, the New York State-operated Project Liberty has provided crisis and short-term counseling and outreach to tens of thousands of New Yorkers, including more than 10,000 Asian Americans in the year following the September 11th attacks. In addition, several community-based initiatives were launched to serve Chinatown.

However, these programs have provided only limited benefits for Asian Americans, for several reasons. The short-term nature of most initiatives makes them inadequate for vulnerable and at-risk populations, such as those studied, for whom traumatic effects can persist for years. For Asian Americans, this situation is exacerbated by the fact that the population as a whole underutilizes services, and by the fact that the lack of treatment can take a severe toll on mental health status. In addition, many post-September 11th mental health programs have not reached the Asian American population effectively, due largely to a shortage of culturally- and linguistically-competent, trained mental health staff members.

b. Mental health service utilization of study populations

- Low mental health service utilization was typical among survivors of World Trade Center victims, as well as Chinatown's children, elderly residents and unemployed workers.
- Study participants largely perceived professional mental health services to be unhelpful, inappropriate or irrelevant.
- In most of the few cases in which victims' family members sought professional mental health assistance, services were not provided by professionals of the clients' cultural and linguistic background.
- Mental health services were utilized more in acute stages of mental illness or were perceived to be useful only in these stages.

Mental health services were more frequently used by study populations when they were:

- offered in non-clinical settings;
- provided by professionals who shared the client's cultural and linguistic background;
- recommended by a trusted individual, such as a relative, friend or social service provider;
- publicized via in-language radio, in the case of Chinatown.

c. Unmet Needs

General

- Awareness of mental health issues, services and resources should be raised among the two major groups studied: families of Asian World Trade Center victims and Chinatown's children, elderly residents and unemployed workers.

Victims' families

- Research from the Oklahoma City bombing shows that the need for mental health assistance following a trauma can persist for years. In that case, mental

health services were still being utilized three years later. Asian families of victims greatly need long-term professional emotional support to help them cope with their continued sense of loss and the stress associated with changes in the family.

- Victims' families cited the need for information on resources and services that are easily accessible and in their native language.
- Victims' families emphasized the importance of making various forms of emotional support and guidance available to individuals close to them, such as friends and neighbors, who did not know how to interact with them under the circumstances.

Chinatown

- Children in Chinatown need sustained interventions that enable them to interact with adults trained to help them address feelings, thoughts and concerns associated with September 11th.
- Parents, school personnel, and child care providers should be trained to deal with mental health consequences in their children.
- Families in Chinatown need help to deal with stress symptoms due to unemployment, persistent post-traumatic stress symptoms, and increased familial tensions and conflict.
- Geriatric mental health services are required to help the elderly cope with their post-traumatic stress symptoms and their continued sense of hopelessness and helplessness.

d. Service Gaps

- There is a shortage of culturally relevant forms of mental health support.
- World Trade Center victims of Indian descent were the largest ethnic group of Asian victims, and nearly one-half of all Asian victims were of South Asian descent. However, most mental health programs and services, including those designed to serve Asian Americans, lack trained professionals with bilingual capabilities and cultural competence to work with South Asian family members.
- Little targeted outreach to victims' families has been conducted by such major September 11th-related mental health programs as Project Liberty and Asian LifeNet, as well as other community-based mental health providers.
- More Asian victims resided in New Jersey than in New York City. Their family members have even less access to culturally-appropriate mental health care than New York City residents, due to the lack of such service programs outside of the city.
- Few organizations that have provided supportive services to family members of victims are staffed by trained mental health professionals.
- Mental health services need to be linked and coordinated with culturally relevant non-clinical support programs in which family members of victims participate.
- Most front-line, direct service staff members of Project Liberty and September 11th case-management programs lack mental health backgrounds. Mental health training, if any is received, generally is superficial and inadequate. In addition, some programs do not have enough Asian-language-speaking staff members.
- Few victims' family members or affected individuals in Chinatown have received ongoing mental health care. Post-September 11th mental health assistance has focused on initial assessment and/or crisis intervention, with few referrals to longer-term services.

Public Policy Recommendations

Goal 1: Develop more culturally competent mental health services and other forms of support.

Key Recommendations:

- Continued funding commitments from federal and state government as well as private foundations are necessary to address the long-term mental health needs of affected populations, with considerations for culturally competent mental health services that incorporate practices based on alternatives to existing Western clinical models.
- Linkages should be strengthened between mental health services and other programs or venues where individuals and families go for concrete help or emotional support.

Goal 2: Create greater awareness of mental health issues and knowledge of bilingual services and resources through expansion of outreach and community education.

Key Recommendations:

- Special outreach efforts should be extended to families of Asian World Trade Center victims, particularly South Asian families as well as families living in New Jersey.
- Information about available services for victims' families in the New York metropolitan area should be centralized, available in relevant Asian languages, and otherwise made easily accessible.
- More mental health education materials should be developed by culturally-competent professionals with relevant field expertise in areas such as bereavement, child psychology or geriatric mental health.

Goal 3: Increase the availability and accessibility of community mental health programs that address the long-term needs of victims' families.

Key Recommendations:

- Direct funding to culturally competent programs, including non-traditional and community-based forms of support within the home communities of victims' families, with emphasis on their long-term mental health needs.
- Programs that help victims' families ease stress associated with changes in the family, such as increased financial obligations, family responsibilities or related culturally-based conflicts, should be encouraged. Emotional support and guidance should also be extended to individuals who are close to these families, including friends and caregivers.
- Mainstream coordinating organizations, such as the Mental Health Association, the American Red Cross, and 9/11 United Services Group, should work more closely with existing community mental health programs to serve victims' families more effectively.

Goal 4: Strengthen the ability of mental health services to assist children, the elderly and families in Chinatown.

Key Recommendations:

- Direct funding to develop a wide range of traditional and non-traditional mental health programs that specifically help children, the elderly, and families in Chinatown cope with the long-lasting emotional impact of September 11th.
- Mental health service providers should collaborate more closely with community-based programs and institutions serving children, the elderly, and adults of working age to facilitate ongoing and more effective intervention for these populations.

Goal 5: Increase mental health training and bilingual capabilities of front-line staff for programs serving victims' families and Chinatown populations.

Key Recommendations:

- Culturally competent mental health training and relevant bilingual capabilities should be required of front-line staff for case management, health service, and other social service programs serving victims' families and Chinatown populations in the New York metropolitan area.

- FEMA/Project Liberty, the American Red Cross, The September 11th Fund, and Mental Health Association should collaborate with Asian American mental health experts to develop mental health training courses and materials that are relevant to these populations.

Goal 6: Expand community and professional knowledge and practice base regarding Asian American mental health issues and programs.

Key Recommendation:

- Direct funding to support further study, including longitudinal research on victims' families and more in-depth needs assessments of vulnerable populations in Chinatown, as well as further development of culturally competent mental health practices to serve Asian Americans affected by September 11th experiences.

Goal 7: Develop a coordinated Asian American community mental health planning framework for a post-September 11th era.

Key Recommendations:

- Mental health planning for future disasters should include considerations of the cultural competence and linguistic appropriateness of services for Asian Americans in the New York metropolitan area.
- Coordinated planning efforts should be supported among community mental health service providers to increase mental health service utilization through effective community outreach; improved access to available services; strengthened service infrastructure; better coordination in service referrals; greater cultural competence in service provision; development, implementation, and evaluation of best practices; and greater ability to inform mental health policy affecting Asian Americans.
- The New York State Office of Mental Health should demonstrate an ongoing commitment to ensuring that cultural competence and other quality-of-care standards are met in its funded and certified programs with respect to services for Asian Americans. Such institutional commitment should be clearly operationalized by, at minimum, assigning responsibility for this issue to senior level staff and institutionalizing processes for participation of Asian American mental health professionals in OMH program planning and policy development.

II. Introduction

Scope and Purpose of This Study

Asian American Mental Health: A Post-September 11th Needs Assessment represents the first broad-scale research project to examine the post-September 11th mental health status and needs of Asian Americans in the New York City area. Designed to provide critical information and guide service planning, this report illuminates the emotional impact of the tragedy on Asian Americans, analyzes their ongoing psychological needs, gauges how well these needs have been met, and pinpoints service gaps. The ultimate product of this research effort is a set of recommendations aimed at making mental health care more available, germane, and helpful to community members who have been experiencing negative emotional reactions after September 11th.

This assessment highlights the post-September 11th experiences and needs of two major groups within the Asian American community: 1) family members of World Trade Center (WTC) victims of Asian descent, and 2) vulnerable populations in economically devastated Chinatown: specifically, children, the elderly and unemployed workers. At the time the research was conducted, there were no in-depth, qualitative studies conducted on the mental health of victims' family members. And, little research attention has been paid to September 11th-related mental health effects on particular ethnic groups or neighborhoods. The Federation launched this study to fill a void in September 11th research, as well as to probe needs suggested by circumstances and characteristics that make these Asian American populations especially vulnerable.

Studies of the General Population

The multifaceted aftermath of the September 11th tragedy continues to unfold. While physical reconstruction and economic rebuilding move forward, research shows that individuals and families across the New York metropolitan area are still struggling to reassemble their lives.

Several research projects have recorded significant mental health repercussions among New Yorkers as a whole, as well as among population subsets. For example:

- In the year following September 11th, studies focused on the World Trade Center attacks documented an increase in mental health problems among children and adults throughout New York City².
- The New York Academy of Medicine (NYAM) found that 13% of Manhattan residents showed symptoms of post-traumatic stress disorder (PTSD) after September 11th. Subsequent NYAM surveys revealed that more than 90,000 New Yorkers continued to experience chronic PTSD symptoms, such as flashbacks, nightmares and social withdrawal³.

² Galea, *et al.*, 2002; Applied Research and Consulting, *et al.*, 2002.

³ Galea, *et al.*, 2002.

- The New York City Board of Education concluded from a study that roughly 200,000 of the 712,000 public-school students in Grades 4 through 12, or more than one-quarter of these students, were candidates for mental health intervention⁴.
- In another study, 61% of adult participants living in New York City-area households with children indicated that September 11th events had upset at least one of those children⁵.

Related Information on Asian Americans

Census statistics point to the substantial and rapidly growing representation of Asian Americans in New York City. According to Census 2000, people of Asian origin comprise nearly 11% of city residents. And, a 71% surge in Asian American New Yorkers' numbers from 1990 to 2000⁶ made them the city's fastest-growing racial group in the last decade.

The large number of World Trade Center victims of Asian descent also lends credence to studying the emotional consequences of September 11th for their survivors. Of the 2,743⁷ people who died as a result of the WTC attacks, 184⁸ individuals, or 6.7% of the victim population, were Asian. Furthermore, four Asian countries – India, Japan, China and the Philippines, in descending order – are listed in the top ten countries of victims' origin⁹. Population data, ethnicity of World Trade Center victims, and knowledge of Asian Americans based on other research offer solid evidence to warrant an in-depth evaluation of the emotional toll of the tragedy on New York-area Asian Americans.

The pervasiveness of the impact necessitates psychological help for impacted individuals. However, while research shows that Asian Americans report higher levels of some common mental health issues, such as depression, they also seek emotional help less frequently. Social and cultural explanations for Asian American underutilization of psychiatric services include shame and stigma associated with personal problems, reliance on family for help, misconceptions about counseling, availability of alternatives to traditional counseling, linguistic barriers, and a shortage of culturally sensitive professionals¹⁰. These factors do not indicate a lack of need for services among Asian Americans, because this population experiences serious mental health issues¹¹. Rather, these aspects illustrate unique barriers to service use.

Asian American students actually display higher rates of psychiatric symptoms than European American students, with higher levels of reported depression and social anxiety¹². Asian Americans who do use services tend to have severe mental health disorders¹³. Asian Americans also are more likely than European Americans to prematurely end psychotherapy¹⁴. Studies have demonstrated that compared with European Americans, Asian Americans use mental health services less¹⁵ and generally are less likely to disclose emotional and interpersonal problems¹⁶.

⁴ Applied Research and Consulting, *et al.* 2002.

⁵ Schlenger, *et al.*, 2002.

⁶ This is using the Asian In-Combination tabulation. When compared to the Asians Alone category with 1990 Asian numbers, the population increased by 54%.

⁷ New York City Department of Health and Mental Hygiene, March 2003

⁸ In January 2003, the Federation compiled a list of all known deceased WTC victims of Asian descent using reports from the New York City Department of Health and victims' profiles from the following websites: *The New York Times*, *CNN*, *MSNBC*, and www.september11victims.com.

⁹ Lipton, 2002.

¹⁰ Loo, *et al.*, 1989; Morrissey, 1997; Root, 1985; Tsai, *et al.*, 1980.

¹¹ Gim, *et al.*, 1990; Solberg, *et al.*, 1994; Tracey, *et al.*, 1986; Ying & Miller, 1992.

¹² Okazaki, 1997.

¹³ Sue, 2002.

¹⁴ Zane, *et al.*, 1994; O'Sullivan, *et al.*, 1989.

¹⁵ Atkinson, *et al.*, 1995; Matsuoka, *et al.*, 1997; Sue, *et al.*, 1991.

¹⁶ Tracey, *et al.*, 1986.

Special Circumstances in Chinatown

A closer look at the Asian American population in New York City reveals Chinatown as an area in particular need of formal mental health care, based largely on geographic and economic characteristics.

Studies indicate that the incidence of PTSD symptoms increases with residential proximity to the World Trade Center site¹⁷. Chinatown's location alone, less than 10 blocks from Ground Zero, heightens mental health risks for its residents – especially children, elderly, and workers who lost their jobs as a result of September 11th. According to one study, children living south of Canal Street were four times more likely to have witnessed the World Trade Center attacks than children in other areas of the city¹⁸.

Chinatown's unprecedented levels of business closures and job losses in the aftermath of September 11th also exacerbate its population's susceptibility to emotional trauma¹⁹. Psychologists often see mental health problems, such as depression and feelings of hopelessness, spiraling from unemployment²⁰. In a recent study, researchers found that people who attributed their job losses or wage reductions to September 11th were likely to identify a need for mental health support²¹.

Despite these added vulnerabilities, little has been documented on Chinatown's specific mental health needs in the wake of September 11th. Many key studies, such as those by the NYAM, Columbia University, and the American Red Cross of Greater New York, have focused on New York City's or Manhattan's entire population and have underrepresented or not included Chinatown. For example, the NYAM conducted its telephone survey of Manhattan residents solely in English and Spanish, thereby overlooking the needs of Chinatown residents, many of whom require Chinese-speaking interpreters or interviewers. Other research projects have investigated the needs of at-risk groups but have not included Chinatown in their study populations²².

However, the experiences of three Asian American service agencies provide some insight into post-September 11th mental health needs and service usage among Asian American New Yorkers. Asian Americans for Equality (AAFE), a community-based organization, found that from May 3, 2002 to August 26, 2002, 82% of Asian American individuals who sought social services reported anxiety or sadness²³. The Chinatown-based Charles B. Wang Community Health Center observed that emotional-distress levels among its clients remained high five months after the disaster²⁴. In addition, the Mental Health Association of New York City's Asian LifeNet found that Asian Americans were particularly hesitant and slow in seeking post-September 11th emotional counseling, compared with other ethnic groups²⁵.

In response to such findings, Asian American services, including Asian LifeNet, the Mental Health Bridge Program at Charles B. Wang Community Health Center, and community-based Project Liberty partners, mobilized as conduits to mental health resources. Yet, even with these efforts, cultural, social and systemic barriers have created difficulties in assessing, measuring and serving New York-area Asian Americans.

¹⁷ Galea, *et al.*, 2002; American Red Cross of Greater New York, 2002.

¹⁸ Belden, *et al.*, 2002.

¹⁹ Asian American Federation of New York, April 2002; Asian American Federation of New York, November 2002.

²⁰ Duenwald, 2002.

²¹ Urban Justice Center, 2002.

²² New York City Department of Health, 2001; McKinsey & Co., 2002; Urban Justice Center, 2002.

²³ Asian Americans for Equality, 2002.

²⁴ Chen, *et al.*, 2002.

²⁵ *World Journal*, September 2002.

Against this knowledge and service backdrop, the Federation sought to learn more and to share the products of its research with community and government leaders who could plan and implement necessary service improvements.

Research Approaches for This Study

The research team applied an integrated research framework, employing both qualitative and quantitative methods.

Qualitative components included:

- One-on-one in-depth interviews²⁶ with World Trade Center victims' family members;
- Focus group discussions with vulnerable populations in Chinatown;
- One-on-one and group interviews with mental health service providers in Chinatown;
- Phone interviews with social service administrators and staff of organizations providing post-September 11th relief services and case management.

Quantitative aspects of the study included:

- A survey of Chinatown-based mental health²⁷ and social service providers;
- A demographic, social and economic profile of Chinatown, drawn from Census 2000 sample data;
- A (GIS) mapping analysis of Chinatown's physical access to mental health services, including data on the neighborhood's population, mental health service providers, and transportation modes;
- A quantitative analysis of service utilization based on data from large mental health and relief service programs serving Asian Americans, such as Project Liberty²⁸, Asian LifeNet²⁹, and the American Red Cross³⁰.

Report Structure

This report is organized as follows:

Chapter 1 describes experiences of survivors of World Trade Center victims of Asian descent, with respect to their 1) psychological and physical reactions associated with September 11th and 2) ways of coping with the tragedy. It includes demographic analyses, along with data on Hamilton-Madison House's Project Liberty program, the largest crisis-counseling and mental health referral source for Asian Americans in the New York City area.

Chapter 2 examines the overall characteristics and mental health needs of children, elderly residents and unemployed workers in Chinatown. The chapter presents a census-based demographic profile of Chinatown as a whole. In addition, the chapter portrays the magnitude and nature of mental health needs of the Chinatown populations studied, based on an examination of information from mental health and social service providers.

Chapter 3 covers available mental health services, service usage, unmet needs and service gaps for the Asian American groups studied following September 11th. Drawing on input from those affected and data from service providers, the chapter highlights the range of needs that still must be addressed.

²⁶ Interviews and focus groups were conducted in the native language of the study participants when appropriate. Of the victims' families' interviews: fifteen were conducted in English; five were in Korean; one was in Hindi; and one was in Mandarin. All of the Chinatown focus groups were conducted in Chinese; (i.e., Cantonese and Mandarin), with the exception of the children's groups, which were all conducted in English.

²⁷ The focus of this study is primarily on outpatient or fee-based mental health services. The topic of serious or chronic mental illness (SMI) lies largely outside the scope of this study.

²⁸ N = 13,859; From October 2001 to September 2002, Project Liberty/Hamilton-Madison House assessed 13,859 individuals.

²⁹ N = 3,599; From January 2001 to June 2002, 3,599 calls were received by the Asian LifeNet hotline.

³⁰ N = 315; From September 2001 to February 2003, 315 Asian victims' families were served by Red Cross.

Chapter 4 recommends concrete solutions to help upgrade services to match the magnitude and nature of post-September 11th needs in the New York area's Asian American community. These action steps are targeted to make services more accessible, relevant, and effective for Asian American populations.

Methodological Considerations

The research team conducted in-depth interviews with survivors of 22 Asian victims, 11 of whom were of South Asian descent. This reflects the overall demographic pattern showing that half of the Asian victims' were South Asian. Using a variety of institutional, community and personal outreach and recruitment strategies, the research team interviewed study participants on a voluntary basis. Though the findings may not be generalizable to the wider victims' families population, this in-depth analysis reveals critical insights about the experiences of these families in dealing with their loss associated with September 11th.

The focus group sessions conducted in Chinatown focus on three vulnerable populations: elderly, children and dislocated workers. The research team targeted participants in daycare centers, senior centers and job training programs in the community. It did not focus on the experience of residents that did not use social services. Again, due to this targeted approach on participants who are part of the social services network and the voluntary nature of focus group participants, the generalizability of these findings is naturally limited. Nonetheless, the research, which is the first-ever-systematic attempt to assess the mental health impact on a neighborhood close to Ground Zero, documents the untold and important experiences of Chinatown residents and workers in coping with the tragedy.

The Project Liberty information on victims' families and Chinatown represents a collection of quantitative data by the largest September 11th community-based mental health program serving Asian Americans. As such, the inclusion of this program data on mental health symptoms and referrals was imperative. However, caution should be employed in interpreting these findings, as the intake form, the data from which the study's analysis was based, was designed to be a Project Liberty program implementation tool rather than to serve as a research instrument. The quantitative data provide a supplementary basis for supporting or refuting the qualitative findings.

Overall, this study fills an important gap in understanding the mental health consequences of September 11th on Asian victims' families and on Chinatown. The findings in this report provide an important knowledge base for mental health policy making and practice as well as an important baseline for future longitudinal research on victims' families and Chinatown community residents.

III. Chapter One: The Mental Health Impact of September 11th on Asian³¹ Victims' Families

Of the 2,743³² individuals who perished in the World Trade Center (WTC) tragedy, 184, or 6.7%, of these victims were Asian. It is notable that, among these victims, nearly half³³ were of South Asian descent. Countless lives, especially those of the victims' family members, were permanently and profoundly altered by these losses.

"...But, you know, the impact is forever...it's there all the time; it's never going to (go) away."

While considerable media attention has been focused on the experiences of World Trade Center victims' family members in general, the distinct and diverse voices of the significant numbers of affected Asians have been relatively unheard. Asian victims' family members come from a range of ethnic and socioeconomic backgrounds, and they live in Manhattan, other boroughs, New Jersey and nearby states. Since the tragedy, these families have been struggling with challenges that have emerged on multiple levels, including bereavement and trauma, increased familial responsibilities, frequently obstructed access to financial and other concrete assistance, the sudden loss of legal resident status in this country, and a host of prejudicial experiences directly related to September 11th. To compound these difficulties, their coping strategies are embedded in a culture that restricts the disclosure of feelings to strangers and discourages use of mental health services.

The objective of this chapter is to provide an understanding of the magnitude and nature of the impact of September 11th on the mental health status of victims' family members. This chapter sets the backdrop for the report's broader goal of identifying steps to enhance access to, and improve delivery of effective mental health services for this population.

The chapter begins by examining the demographic profiles of the entire population of Asian victims, as well as the group of victims' family members interviewed for this study. It then presents interview findings, focusing specifically on: 1) psychological and physical reactions associated with the September 11th tragedy; 2) methods of coping after the tragedy; and 3) other September 11th issues pertinent to the Asian community.

³¹ The term "Asian" in this chapter describes individuals of Asian descent and includes both Asians and Asian Americans.

³² *Summary of Vital Statistics, 2001*, The City of New York, Bureau of Vital Statistics, New York City Dept. of Health and Mental Hygiene, March 2003.

³³ From number of victims for whom ethnicity was identifiable.

A. World Trade Center Asian Victims: Demographic Profile

Of the 2,743 estimated World Trade Center deaths, 6.7%, or 184 victims, were of Asian descent. The number of Asian deaths was the fourth largest racial category, preceded by non-Hispanic whites (76%), Hispanics (10%), and African Americans (8%)³⁴. Reflecting 15 different ethnocultural subgroups, the Asian demographic profile paints a picture reflective of the overall diversity of this racial category.

"I'm sure most of the Korean victims' families have the same feelings... same attitude... not actively pursuing (help)."

While the locales of residence spanned nationally as well as globally, the overwhelming majority of victims resided locally. Of the 166 Asian victims for whom residence was known, approximately

- 37% (62) resided in New York City³⁵;
- 13% (21) resided in New York State, but outside of New York City;
- 42% (69) resided in New Jersey;
- 7% (11) resided in other states, and
- 2% (3) resided internationally.

The Asian ethnicities with the greatest number of victims were Indian (46), Chinese³⁶ (36), Japanese (23), and Korean (16). Of the Asian victims for whom demographic information was known, an overwhelming majority (77%) of Asian victims were married; and more than twice as many men (69%) were among the victims as women (31%). The largest age bracket of Asian victims (38%) was between the ages of 30 and 39, while 24% were between ages 20 and 29. An additional 24% were between ages 40 and 49, and 14% were 50 years or older.

The Asian victims' diversity was also reflected in their varied experience and industry background. Of those for whom occupation or occupational industry³⁷ was known, 25% (37) were employed in the finance industry; 23% (36) were employed in the computer technology industry; 12% (19) were employed in the accounting industry; and 6% (9) were in the restaurant industry.

Clearly, the Asian victims' profile shares a story not only of diversity, but one of the many young talents that were lost as a result of the World Trade Center attacks. Please see Appendix D for more information about this population.

B. Study Participants: Demographic Profile

In July and August of 2002, interviews were conducted with 22 victims' family members of Asian descent. These individuals came from diverse ethnic, economic, and social backgrounds and resided throughout Manhattan, Queens, Staten Island, Long Island, New Jersey, and across other U.S. states. All of the participants were immigrants and adults, with lengths of stay in the U.S. ranging from one to 35 years. The majority of the participants were women, and almost half of all participants were spouses of the deceased. The other half was largely comprised of parents and siblings. Generally, the group of participants was educated; the majority of the participants were college graduates, and nearly half had attained education at the graduate level.

"The need depends on the situation. It's still there but I think it's just harder for Asians to get help... at least at first or right away."

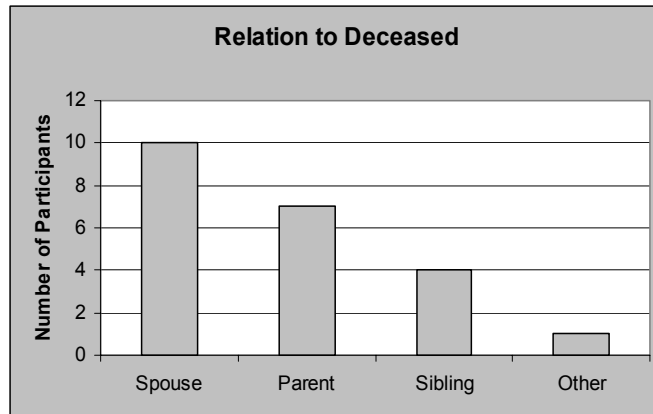
³⁴ Based on 2,743 victims as listed by Department of Health (March 2003) *Summary of Vital Statistics for 2001*.

³⁵ Of the Asian victims who resided within New York City, 56% (35) resided in Manhattan, 26% (16) resided in Queens, 15% (9) resided in Brooklyn, 3% (2) resided in Staten Island, and 0% (0) resided in the Bronx.

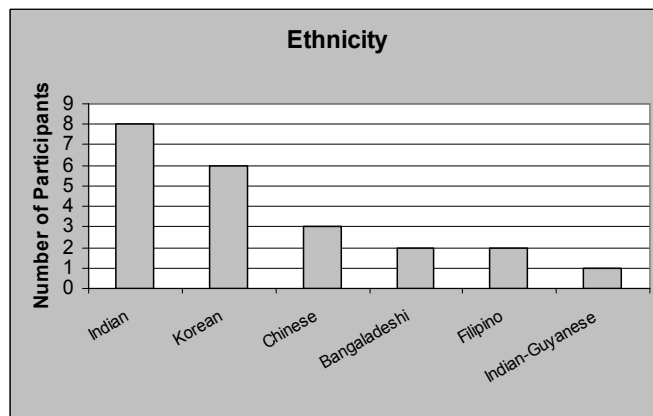
³⁶ Excludes Taiwanese.

³⁷ More specific industry information on occupation categories in the data set, such as "Broker," "Analyst," and "Consultant," was not available, so industry (e.g., Finance) totals may actually be higher.

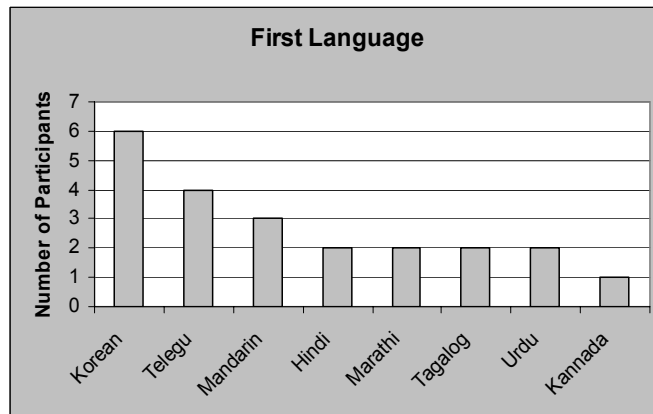
1. **Relation to deceased**: Spouse: 10; Parent: 7; Sibling: 4; Other relative: 1



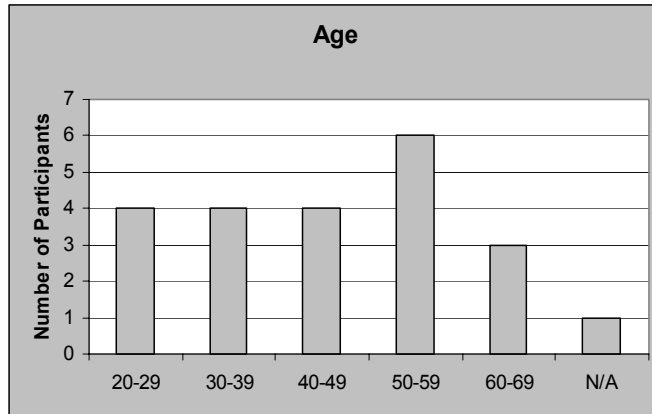
2. **Ethnicity**: Indian: 8; Korean: 6; Chinese: 3; Bangladeshi: 2; Filipino: 2; Indian-Guyanese: 1



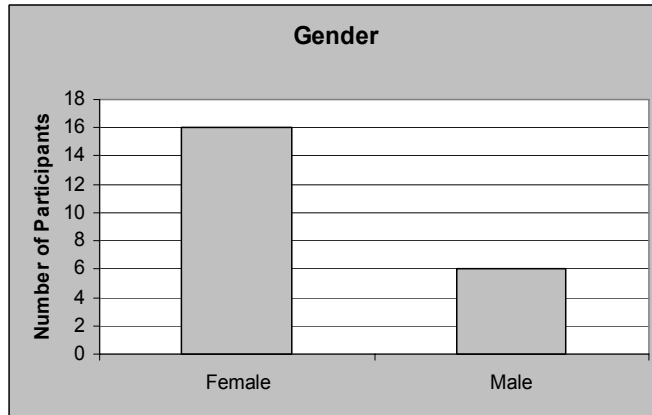
3. **First language**: Korean: 6; Telegu: 4; Mandarin: 3; Hindi: 2; Marathi: 2; Tagalog: 2; Urdu: 2; Kannada: 1



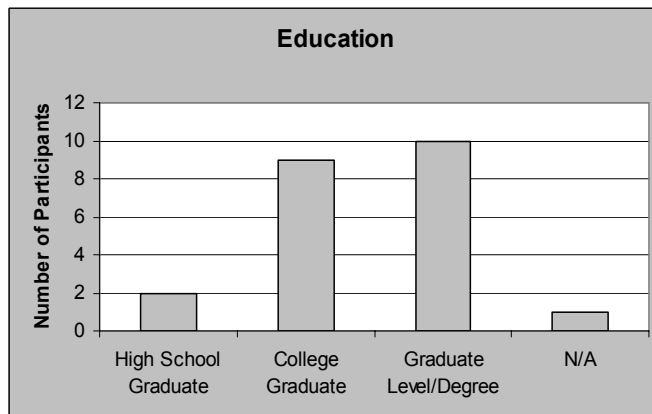
4. **Age:** Age 20-29: 4; Age 30-39: 4; Age 40-49: 4; Age 50-59: 6, Age 60-69: 3; N/A: 1



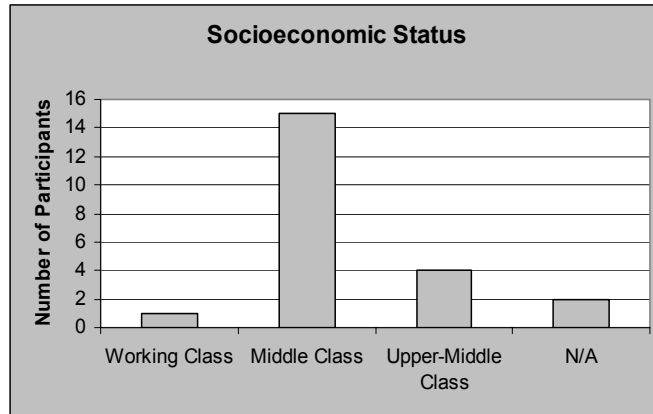
5. **Gender:** Females: 16; Males: 6



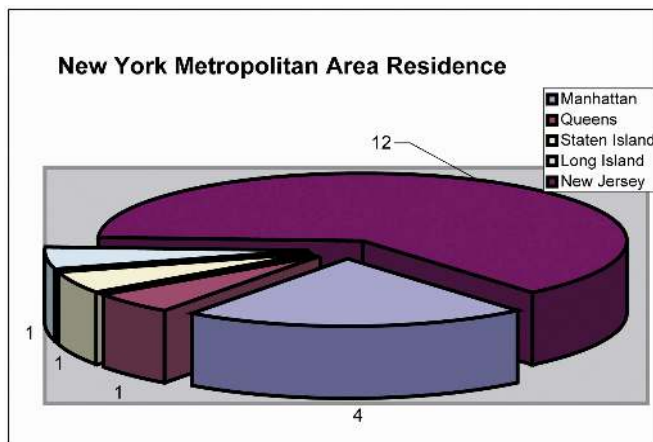
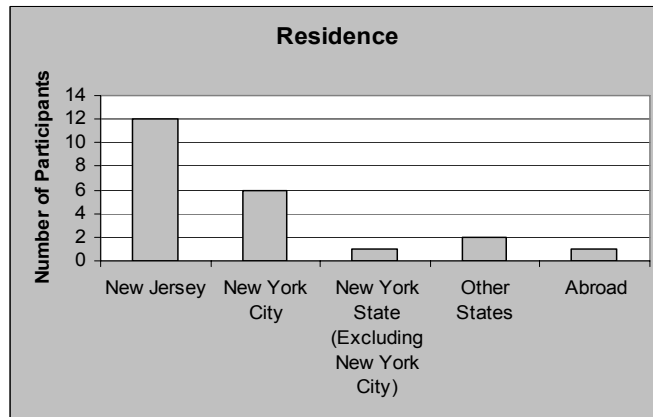
6. **Education:** High school graduates: 2; College graduates: 9; Graduate level/Graduate degrees: 10; N/A: 1



7. **Socioeconomic status**³⁸: Working class: 1; Middle class: 15; Upper middle class: 4; N/A: 2

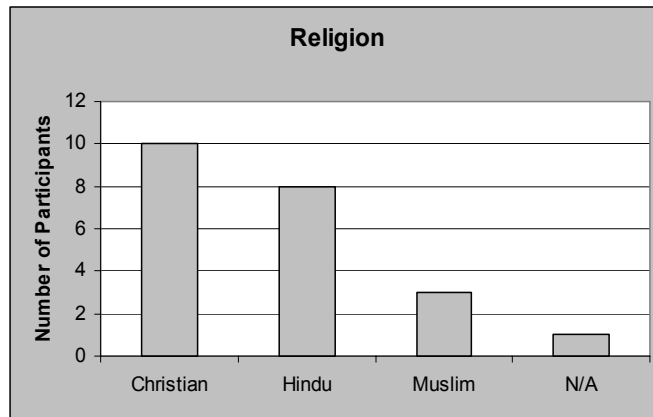


8. **Residence**: New Jersey: 12; New York City: 6; New York State (excluding New York City): 1; Other states: 2; Abroad: 1



³⁸ Reflects participants' definition of these socioeconomic categories, rather than standard indicators.

9. **Religion:** Christian³⁹: 10; Hindu: 8; Muslim: 3; N/A: 1



C. Study Participants: Interview Findings

Study participants were asked about their reactions to the September 11th tragedy and the ways in which they coped with the loss of their family member. Interviews showed that participants experienced a range of psychological and physical symptoms as a result of their loss. Coping for both the participant as well as their family members involved using informal (e.g., families & friends) and alternative methods of healing (e.g., palmists, astrologers, etc.), methods that were embedded within culture-specific contexts. Professional counseling was generally perceived as unhelpful.

"...That was the first time I heard my dad cry. He's such a strong man; he was an army person... I saw for the first time my dad cry, and it was really bad."

1. **Psychological and physical reactions associated with the September 11th tragedy**

In order to explore reactions and feelings associated with the September 11th tragedy, participants were asked how they had been feeling for the past nine to ten months and how feelings may have changed.

Participants experienced a range of psychological symptoms in reaction to their loss, including denial, anger, and hopelessness. Sleep problems were widely reported as one of the physical reactions. Physical symptoms were widespread – a salient finding for a population for whom underlying emotional issues tend to manifest themselves as more culturally acceptable health conditions. Based on the reported symptoms, every study participant was perceived by the interviewers, who are professional mental health clinicians, to be depressed or mildly depressed.

Psychological reactions

"A few nights back, I was looking at the movie, and there was this fire and everything, and when I woke up at night, I am like oh, am I still dreaming, am I dreaming, or is this real? I still wake up 'til this day, ten months after, I still believe that maybe [my husband] is somewhere out there, because I haven't seen his body... I haven't seen his body, even though the community, the mosque and everybody there, the members, they said that we have to do a funeral service for him. I was very much reluctant. You know, I was still hoping that we would find his body and do it."

All participants indicated the following psychological (emotional, behavioral, and cognitive) reactions:

- Missing the victim and wishing the victim would return;
- Denial that the victim is gone;

³⁹ Participants identified as "Protestant," "Catholic," and "Christian."

- Sadness, loneliness or emptiness, and anger or irritability about the senseless loss;
- As time progressed, psychological reactions intensified;
- Extreme change in activity level expressed through an inability to maintain daily activities;
- Eventual return to daily routines despite worsening psychological reactions;
- Isolation/withdrawal and lack of interest in things or in life.

South Asian participants also indicated the following additional psychological reactions:

- Initial hope gradually diminished and superstitions and fears increased;
- Anxiety;
- Experiencing “why me” syndrome;
- Lack of focus, normalcy, and life meaning;
- Suicidal thoughts or feelings, not wanting to live within the context of this tragedy;
- Lack of closure due to not being able to obtain remains of the body and regrets due to the inability to fulfill dreams or resolve past conflicts;
- Emotional numbness and inability or difficulty expressing emotions;
- Uncertain future or increased career dilemmas.

Physical Reactions

“Anything triggers me because every day of routine also reminds you of some small things that used to be there. So, like, I don’t sleep at night, but I don’t want to get up in the morning. I keep lying, even though I am not asleep, I keep lying in bed. Don’t want to open my eyes. (Pause) And I keep seeing the picture of the building collapsing in front of my eyes, all the time. ...I keep listening to these different kinds of voices, as if somebody’s calling me, or sometimes he’s calling me, that he wants me.”

All participants indicated the following physical reactions:

- Sleeping problems

South Asian participants indicated the following additional physical reactions:

- Changes in appetite;
- Loss of hair;
- Darkening of skin color;
- Poor memory & concentration.

The other Asian participants experienced:

- Heart palpitations;
- Blood pressure problems;
- Physical pain.

2. Ways of coping with the tragedy

“Um...we’ve been going to church and our...our pastor, pastor and his wife have been wonderful. So we’ve been praying a lot, trying to find some kind of peace through the church basically. Um...we’re not very comfortable with counseling and trying to express our feelings to a stranger. We don’t mean to be rude, but we feel more comfortable... I mean it’s difficult either way, but we feel more comfortable in a church. We deal with it through a lot of prayers.”

The participants were asked how they had dealt with the loss of their family member and what they did when difficult feelings arose for them. Reactions of both the participant and their respective family members were discussed.

Participants coped with their losses in several different ways. Avoidance and self-distraction were the most common methods of dealing with the loss. Also, coping for

both the participant as well as their family members involved using informal (e.g., family and friends) and alternative methods of healing embedded within culture-specific contexts (e.g., palmists, astrologers, etc.). Religion and spirituality played an especially significant role in the way that many participants coped with their loss.

- Avoidance/Self-distraction: Many participants kept themselves busy by working, taking care of children, volunteering, and taking on more responsibility within their families (cooking, going shopping, and exercising). Some tried to extinguish their thoughts, to avoid interactions with others, and to avoid verbalizing feelings.
- Religion/Spirituality: Some participants cited changes in their religious/spiritualistic behaviors - e.g., becoming more religious or less religious; feeling indifferent or having mixed feelings about God; praying; and going to churches, temples, and mosques. Muslims showed an increase in ritualistic/spiritual behaviors as compared to Hindus. Koreans were also particularly religious.
- Maintaining life as usual for children, with a positive emphasis: Participants tried to maintain all the activities that children were involved in and to encourage children to strive for the best.
- Communication/Interaction with others: Many participants stated that they interacted with other victim families and talked to immediate family members.
- Cognitive strategies: Some tried to make sense of, or rationalize, the tragedy.
- Remembering the deceased: Participants would constantly relive and recollect memories of the deceased (e.g., speaking about the deceased, viewing photographs and videos). Some even reported talking directly to the victim. Many provided children with opportunities to have a sense of connection to the victims, such as attending memorials.
- Changing personal outlook: Some developed a fatalistic attitude towards death, dying, and life in general.
- Indigenous healing: Some would seek astrologers, pray, and/or talk to face readers or palmists.
- Expression of emotions: Many would cry and get angry.

Professional mental health services were utilized very minimally and widely perceived to be unhelpful, inappropriate, or irrelevant to participants personally and/or culturally. Resistance to mental health service use was based in part on misconceptions about counseling, which include the belief that it will not help and that, in fact, talking will only make one more depressed. The perception of it as a last resort or an option to consider only in extreme circumstances, such as suicidal ideation, also deterred participants from mental health service use. The stigmas associated with mental health service use and the acknowledgement of mental health issues in general were also evident in expressed fears of being perceived by others as “crazy,” weak, or incompetent to handle one’s own problems.

In addition, Asian cultural ideals such as self-reliance or exclusive reliance on one’s family to endure and resolve problems were also cited as reasons why participants were not interested in counseling. Indeed, in many cases, sharing one’s problems at all, including with family members, was considered exerting an undue burden on another person. Cultural values placed on reservation and non-expression sanction avoidance of morbid thoughts and worries over verbalizations of emotions in times of emotional distress. The participants perceived little benefit in confiding in a stranger. Among the victims’ families, in particular, fatalistic perspectives, such as the belief that an individual has no control over what has happened, and that nothing can be actively changed about the situation, also justified not using services.

3. Other September 11th-related challenges

“And they said...that your husband is not here, so you do not have any status...And I said that this cannot happen...they said that you have two options – either give us money and take your passport or we will send you back to India tomorrow...and they asked ‘Why are you here?’ I have everything here – my husband’s memories are here, I have everything here and I need to work here, I need to live here and I even brought my son here from India, I have proof. [They said] ‘we made a mistake in September to let you enter. You couldn’t have entered even then, and you are not even eligible for any of the funds because you were not here in September.’ I told them that I was on vacation in India. How could I know that on September 11th all this is going to happen?”

The following delineates other difficult experiences faced by the study participants in the midst of grieving over the loss of the victim. These issues have compounded the emotional impact of the tragedy and should be considered closely in the provision of mental health care and other supportive services for victims’ family members of Asian descent.

- Additional familial responsibilities: Very few participants denied any changes within the family. Most mentioned that family dynamics have changed, or that they have taken on additional responsibilities after the tragedy. There was variability in the degree to which participants expressed changes in roles and responsibilities within the family. Many of the study participants talked specifically about the necessity of fulfilling their own roles as well as the role of the victim within the family. For example, one of the participants who lost her significant other stated, *“It seems I have to take the role of, ah, myself and my husband at the same time.”* Furthermore, the interviewees who lost their siblings indicated an increased sense of responsibility towards their parents. Since Asians tend to place strong emphasis on family roles and obligations, such changes in family dynamics and added pressures in family roles are critical to consider when mental health needs are assessed.
- Perceived discrimination when accessing services: The interviews also revealed initial, negative perceptions of study participants about how they were treated when trying to access concrete services. Specifically, many of the study participants believed that they were treated unfairly and experienced many barriers when trying to get help, whether it was financial, emotional, or logistical support. Participants reported feeling discriminated against due to their cultural background and/or level of English language fluency.
- Difficulty navigating the system: Some participants reported extreme difficulty getting any kind of assistance even though there was considerable media coverage about the resources and support available to victims’ families. Often, applications were not available in Asian languages, and/or Asian language-speaking relief center staff were not available to assist them.
- Next of kin issues: Many of the participants reported difficulties in gaining access to compensation and benefits, because they were not considered “next of kin” or immediate family members, a required relationship for benefit eligibility. This barrier imparted a great deal of frustration and stress on victims’ families, because it does not correspond with Asian values. In some traditional Asian cultures, parents can expect to depend on their married children for financial support.

Concerns specific to the South Asian participants

- Immigration concerns: Upon the death of the victim, many family members lost their legal resident status in the United States. Half of the participants reported difficulties obtaining assistance from the INS as well as difficulties in obtaining visa extensions for themselves and family members. These circumstances created heavy stress and intensified uncertainties about the future.

- Increased expenses: Legal issues arising from September 11th created increased financial obligation, e.g., use of personal attorneys.
- Prejudicial experiences: In the time following September 11th, half of the participants were targets of prejudice on the basis of their clothing and/or appearance and reported feeling fearful during this time for that reason. Participants responded by wearing pins, putting up flags, and not engaging in certain South Asian rituals (e.g., wearing bindis). Several participants spoke of forgiving prejudicial behaviors under the circumstances of September 11th.
- Other concerns: Participants also identified the following additional concerns related to their experience:
 - Financial concern for family members in India;
 - The need to build a respectful memorial for their lost family member;
 - Lack of sensitivity from the South Asian community (i.e., extended friends and family) with regard to coping.

D. Quantitative Findings: Project Liberty Data

To provide a framework for understanding mental health impacts at the community level, the research team conducted an analysis of service utilization data from Project Liberty, a federally⁴⁰-funded crisis counseling, public education, and mental health outreach program for New Yorkers affected by September 11th. Project Liberty operates through over 70 community-based providers in New York City, including mental health agencies and hospitals. Outreach and assessments are conducted in the community, in locations such as schools, community centers, work sites, individuals' homes, and places of worship.

"If they are around, I go into the bathroom and I cry, every day. I never talk to them about this."

For the purposes of this study, assessment forms from the Project Liberty program operating through Hamilton-Madison House, the largest provider of mental health services to the Asian American community in New York City, were analyzed. Hamilton-Madison House serves all of New York City, but a large portion of its client population resides in Lower Manhattan and Chinatown. The Project Liberty data add another dimension of understanding to the experiences of victims' families and are useful for reinforcing or refuting the findings derived in the interviews. As such, they have implications for informing mental health policy and program planning for this group.

The following is a presentation of key findings from an analysis of the assessments of these individuals. Project Liberty assessments document a spectrum of indicators of mental health status in each of the following categories: i) Behavioral Reactions,⁴¹ ii) Emotional Reactions,⁴² iii) Physical Reactions,⁴³ and iv) Cognitive Reactions.⁴⁴ The employed mode of analysis is purely descriptive; a causal relationship between variables is not implied. All of the documented reactions were current or visible at the time of the assessment.

⁴⁰ Federal Emergency Management Agency (FEMA).

⁴¹ **Behavioral Reactions**: 1) Extreme changes in activity level; 2) Excessive use of drugs, alcohol, or prescription drugs; 3) Isolation/withdrawal; 4) Hyper vigilance; 5) Reluctance to leave home; 6) Violent behavior; 7) Other; 8) None; 9) Unknown.

⁴² **Emotional Reactions**: 1) Sadness, tearfulness; 2) Irritability, anger; 3) Feels anxious, fearful; 4) Despair, hopeless; 5) Feels guilty/shameful; 6) Feels emotionally numb, disconnected; 7) Other; 8) None; 9) Unknown.

⁴³ **Physical Reactions**: 1) Headaches; 2) Stomach problems; 3) Difficulty falling or staying asleep; 4) Difficulty eating; 5) Worsening of chronic health conditions; 6) Fatigue/exhaustion; 7) Chronic agitation; 8) Other; 9) None; 10) Unknown.

⁴⁴ **Cognitive Reactions**: 1) Inability to accept/cope with death of loved one(s); 2) Distressing dreams; 3) Intrusive thoughts or images; 4) Difficulty concentrating; 5) Difficulty remembering things; 6) Difficulty making decisions; 7) Preoccupation with death; 8) Suicidal thoughts or feelings; 9) Other; 10) None; 11) Unknown.

In the year after September 11th ⁴⁵, Hamilton-Madison House assessed 13,859 individuals through its Project Liberty program. The majority, 68.8% or 9,538, of these individuals were Asian or Pacific Islander (API)⁴⁶, according to the intake forms. During this timeframe, a total of 79 victims' family members were assessed. Of these, approximately 30% (24) identified themselves as API.⁴⁷

In general, the victims' family members expressed a high number of negative reactions in each of the aforementioned categories. Furthermore, the incidences of these reactions were substantially higher than those of the total sample population⁴⁸ of victims' families in New York City that were assessed by Project Liberty/Hamilton-Madison House during this time period.

It should be noted that caution should be employed in interpreting these findings; the data represent solely the sample of victims' families assessed by Project Liberty/Hamilton-Madison House and are neither necessarily generalizable to the entire population of Asian victims' families nor to the entire population of Project Liberty clients. While Hamilton-Madison House is the largest Project Liberty provider to Asian Americans, other programs contracted with Project Liberty also serve Asian Americans (See Chapter 3 for a listing of these programs).

1. **Behavioral Reactions:** Seventy percent (70.8%) of API victims' family members expressed one or more behavioral reactions at the time of the assessment, while this was true for 62% of victims' families in the total sample population.
 - Over forty percent (41.7%) of API victims' family members experienced an extreme change in activity level, while the same was true for only 20.3% of victims' family members in the total sample population.
 - One-third (33.3%) experienced hyper-vigilance, while the same was true for only 11.4% of the total sample population.
 - Twenty percent (20.8%) suffered from isolation and/or withdrawal, while the same was true for only 12.7% of the total sample population.
 - More victims' family members in the total sample population (21, 31.8%) expressed "other reactions"⁴⁹, as compared to the API victims' family members (4, 16.67%), suggesting differential expression of mental health impacts by group.
2. **Cognitive Reactions:** Over 60% (62.5%) of API victims' family members experienced one or more cognitive reactions at the time of the assessment, as compared to half (49.4%) of the victims' family members in the total sample population.
 - One-quarter (25%) of API victims' family members assessed expressed an inability to cope with death, as compared to 22.8% of victims' family members in the total sample population.
 - One in five (20.8%) experienced difficulty concentrating, as compared to 15.2% of the total sample population.
 - A greater proportion of APIs suffered from most of the other cognitive reactions, in comparison to the total sample population, including:
 - Intrusive thoughts or images (16.7% vs. 7.6%);
 - Distressing dreams (16.7% vs. 8.9%);
 - Preoccupation with death (12.5% vs. 3.8%);

⁴⁵ Program commenced October 2001; data reflect period of October 2001-September 30, 2002.

⁴⁶ Further disaggregation of ethnicity was not possible due to dataset limitations.

⁴⁷ It should be noted that these individuals are defined as "Family of Missing/Deceased," though some may have been relatives of missing individuals.

⁴⁸ All data is from Hamilton-Madison House/Project Liberty. The total sample population represented is all 13,859 individuals (Asian and Non-Asian) assessed by this program from October 2001 through September 30, 2002. Special emphasis should be placed on the fact that the total sample population is specifically the universe of individuals assessed by Hamilton-Madison House/Project Liberty in New York City and is not a sample necessarily reflective of the entire New York City population.

⁴⁹ "Other reactions" is an assessment category. Due to dataset limitations, more specific data are not available.

- Difficulty making decisions (8.3% vs. 2.5%).

3. Emotional Reactions: All (100%) of the API victims' family members were suffering from one or more emotional reactions at the time of the assessment. The same was true for victims' family members in the total sample population.

- Nearly 80% (79.2%) of victims' family members were sad and/or tearful at the time of the assessment. The same was true for 78.5% of the total sample population of victims' family members.
- One-third (33.3%) of the victims' family members were feeling anxious and/or fearful at the time of the assessment. The same was true for slightly fewer (31.7%) of the victims' family members in the total sample population.
- Thirty percent of API victims' family members were irritable and/or angry at the time of the assessment, as compared to 26.6% of victims' family members in the total sample population.
- Twenty percent (20.8%) of the API victims' family members felt guilty/shameful, as compared to 10.1% of the victims' family members in the total sample population.
- A greater proportion of APIs suffered from other emotional reactions, in comparison to the total sample population, including:
 - Despair and/or hopelessness (16.7% vs. 10.1%);
 - Feeling emotionally disconnected or numb (12.5% vs. 7.6%).

4. Physical Reactions: Nearly 80% (79.2%) of API victims' family members experienced one or more physical reactions at the time of the assessment, as compared to 63% of victims' families in the total sample population.

- 50% of the assessed API victims' families experienced difficulty falling or staying asleep, as compared to 34.2% of victims' families in the total sample population.
- One-third (33.3%) of APIs suffered from chronic agitation, as compared to 19% of the victims' families in the total sample population.
- One in five (20.4%) APIs experienced difficulty eating, as compared to 11.4% of the victims' family members in the total sample population.
- A greater proportion of APIs suffered from other physical reactions, as compared to the total sample population, such as:
 - Headaches (16.7% vs. 7.6%);
 - Worsening of chronic health conditions (12.5% vs. 6.3%);
 - Stomach problems (4.2% vs. 2.5%).

Overall, the Project Liberty data on Asian victims' family members reinforce the interview findings that this group has been suffering from severe impacts in crucial areas of life functioning. Specific psychological and physical reactions raised in the interviews were mirrored by the Project Liberty data, which illuminated the magnitude to which these reactions are prevalent in the larger community. The debilitating effects of these losses are even more dramatic when the reactions of Asian victims' family members are compared with those of the total sample population. Victims' family members of Asian descent suffered higher levels of most categories of reactions than victims' families in the total sample population. The differential expression of reactions could be due to social, cultural, or other environmental factors, such as those described in the interviews that contribute to or are otherwise associated with a greater degree of stress or difficulty coping in the context of the loss.

Summary

Comprising nearly seven percent of all deceased victims of the September 11th tragedy, Asians were the fourth largest racial category represented among the victims. The diversity of the Asian victims is evident in the broad spectrum of their ethnic backgrounds, the scope of industries that these individuals occupied, and the wide ranges in their ages and countries of origin. This diversity is mirrored in their affected families and, as evidenced in the interviews, is a contributing factor to the ways in which family members responded to their loss. Across all the groups interviewed, the experience of this loss was colored by cultural factors and by methods of coping and healing that were generally informal in nature and embedded within culture-specific contexts.

“...nothing can heal wounds we have. This change – this mental position, thinking, will never be changed until our death – an unforgettable incident... this is a lifetime impact.”

As demonstrated by the Project Liberty data, victims' family members of Asian descent suffered extremely high levels of negative impacts to life functioning in the year after September 11th. The interviews with family members elicited possible reasons for the greater degree of difficulties these families may have faced. For South Asians, whose deceased family members made up nearly half of all Asian victims, specific external challenges arose to compound the grief and stress that they experienced upon the death of their family member. For instance, the legal resident status of many families ceased when their family members, who held employment visas allowing the family to live in this country, passed away. Difficulties dealing with the INS and obtaining legal assistance in this regard were great sources of stress. On top of these issues, South Asians reported feelings of fear and anxiety when they found themselves subjects of racial profiling and targets of hate crimes in the aftermath of the tragedy. For a community already grappling with the trauma of losing a family member, these encounters intensified the emotional impacts and feelings of physical insecurity that reverberated from September 11th.

Similarly, for all Asian families, increased financial and familial responsibilities and other commonly-cited external stressors were gravely debilitating at a time of already momentous loss. Racial discrimination perceived from relief center staff when family members attempted to access services and language barriers that prevented them from accessing much-needed assistance also caused excessive stress.

In this light, the importance and necessity of considering the unique backgrounds and personal experiences of affected family members in crafting and providing assistance to these individuals cannot be ignored.

IV. Chapter Two: The Mental Health Impact of September 11th on Chinatown

Asian American Federation research reports titled *Chinatown After September 11th: An Economic Impact Study* and *Chinatown One Year After September 11th: An Economic Impact Study* documented the severe effects of the tragedy on Chinatown's businesses and workers. As defined in the first of those reports, Chinatown⁵⁰ is home to 55,864 Asian⁵¹ residents and 33,658 workers. Chinatown's location just 10 blocks from the World Trade Center, depicted in Figure 1, places its residents, including nonresident workers, at heightened risk for emotional trauma.

"On T.V., I saw people jumping out of buildings and I thought they would die."

In the three months after September 11th, one-quarter of Chinatown's work force became unemployed as a result of massive business downturns triggered by the tragic event. One year later, the majority of workers were still suffering from high levels of underemployment. These bleak economic conditions have intensified the levels of stress and other emotional symptoms experienced by workers and their families – members of an immigrant community whose low socioeconomic status made them vulnerable even before September 11th. In addition, this community historically underutilizes mental health services, placing them at even greater risk for poor outcomes.

Despite these circumstances, the psychological effects of September 11th on Chinatown have not been documented or quantified. To date, no structured community-level assessment of post-September 11th mental health needs has been conducted. In this context, this chapter covers the extent of mental health issues and service gaps in Chinatown, in order to inform service planning for this unique population.

This chapter opens with a census data-based demographic profile of Chinatown residents, providing a contextual framework for understanding mental health issues in the community. Next, it presents findings from a series of focus group discussions with three particularly vulnerable populations in Chinatown: children, elderly residents and unemployed workers. A summary follows of interviews and surveys with Chinatown-based mental health and social service providers looking at the emotional status and needs of the community. The chapter concludes with an overview of mental health impacts within the Chinatown community, using

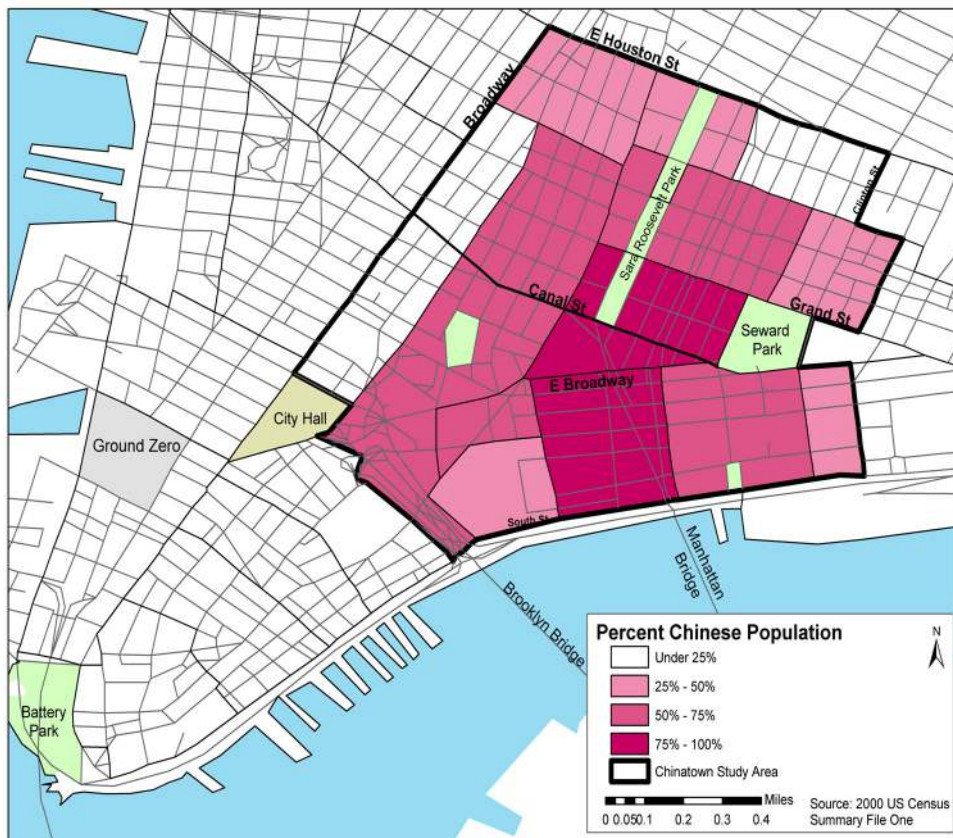
⁵⁰ In delineating the study area, the report characterized Chinatown as a community of Chinese-owned and -operated businesses and Chinese workers.⁵⁰ Chinatown spans four ZIP codes: 10002, 10012, 10013, and 10038. While a number of non-Chinese businesses are established within these ZIP codes, the study area represents only those with the highest concentrations of Chinese businesses and residents. The residential part of Chinatown covers a total of 13 Census tracts. The tracts that were included within the boundary estimation fulfilled the following criteria: 1) has an Asian⁵⁰ population greater than 500 people and 2) the Asian population comprises more than 25% of the total population. Two other tracts⁵⁰ were included within the Chinatown boundary estimation because these contain a significant number of garment businesses, Chinatown's largest industry. According to the New York State Department of Labor (NYSDOL) Apparel Industry Task Force, many of the registered garment factories lie within these two tracts.

⁵¹ Data Source: Census 2000 Redistricting Data (Public Law 94-171) Summary File. "Asian alone or in combination with one or more other race categories", and with one or more Asian groups; people who reported entirely or partially as Asian. The Census 2000 data has not been statistically adjusted to compensate for any undercount.

symptoms data from various mental health administration system sources. These sources include a database of over 10,000 intake assessments from the largest Chinatown-based service provider offering post-September 11th crisis counseling and referrals.

The research team also examined the community's physical access to mental health services, looking at the proximity of mental health service sites to the residential population and to modes of public transportation. The analysis revealed that Chinatown's service sites are concentrated in the area of greater population density and are quite accessible to public transportation. This information is covered in Appendix D.

Figure 1: Chinatown Study Area with Chinese Population Concentrations



Produced by the Asian American Federation of New York

A. Chinatown Neighborhood: Demographic Profile

Demographic characteristics, such as income and poverty status, are crucial elements towards understanding the nature and extent of mental health issues, barriers to mental health services access, and factors associated with effective service delivery and utilization. Census data strongly suggests an Asian population in Chinatown that faced significant socioeconomic challenges before September 11, 2001. In 1999, the per capita income for Asians in Chinatown was only \$12,065, compared to an average New York City per capita income of \$41,887. Nearly one-third of the Asian households⁵² were living in poverty. More than one in three (3,762) Asian children in Chinatown lived below the poverty line, while the City average for Asian children was one in ten. Furthermore, over 40% of these families earned less than \$20,000, and over 60% of Asian elderly households earned less than \$15,000.

"I still feel fearful whenever I think about the 9/11 attack."

Data on Chinatown household size and rent burden suggest even greater economic obligations. Asians in Chinatown had relatively large households compared to the average New York City household. The average Asian household size in Chinatown was 3.14 people, while the average New York City household size was 2.59. This may be explained by the possibility that Asian households are comprised of multiple rent-payers. In light of the low incomes of Chinatown workers, multiple rent-payers may be necessary to alleviate the rent burden. Despite larger households, nearly one in four Asian households paid more than 50% of their household income for rent.

In addition to these economic burdens, Asians in Chinatown faced language and educational barriers. The majority (58.9%) of Asians in Chinatown did not speak English "well" or "at all", and an even greater proportion (79%) of the elderly population had this limited English ability. Furthermore, nearly 70% of Chinatown's Asians did not have a high school diploma, and nearly half had less than a ninth grade education⁵³. To compound these external challenges, Chinatown had a significant concentration of Asian individuals with mental disabilities⁵⁴. The percentage of Asians in Chinatown with some kind of mental disability (7.6%, 3,662) was significantly higher than the overall New York City Asian rate of 2.7%.

Low socioeconomic status is a major risk factor for negative mental health outcomes as it not only predisposes the community to greater levels of economic and social stressors but also restricts various forms of access (e.g., physical and financial) to mental health treatment. In the aftermath of September 11th, the community was further debilitated by the severe economic and emotional consequences of the tragedy.

⁵² A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. The count of households excludes group quarters. There are two major categories of households, "family" and "nonfamily".

⁵³ Universe: Asian Alone Population 25 years and over (39,246).

⁵⁴ To be classified as mentally disabled by the U.S. Census, individuals must have a mental or emotional condition that affects learning, remembering, or concentrating, lasts 6 months or more, and makes the performance of certain activities difficult.

B. Focus Groups: Children, Elderly, and Dislocated Workers

Some populations are considered particularly vulnerable by virtue of social circumstances and characteristics that may limit individual resources, opportunities, and the abilities to meet one's own needs and/or sustain quality-of-life independently. Children are dependent on adults for care, often lacking the communication tools and level of self-awareness to recognize and describe mental health issues to adults. Elderly, particularly the homebound elderly, are prone to social isolation and generally have lower incomes than adults of working-age. In addition, mental health disorders in elderly are frequently mistaken for normal aspects of the aging process and do not get treated⁵⁵. Unemployment status renders dislocated workers particularly vulnerable to stress. For the immigrant population of Chinatown, these vulnerabilities are compounded by low socioeconomic characteristics, including low levels of English proficiency, educational attainment, and income. Through a presentation of focus group findings, this section documents how each group experienced September 11th and discusses current mental health issues in that context. It is notable that, for all the focus group participants, this was the first time they ever discussed their personal experiences and feelings regarding September 11th.

1. Children

In July 2002, ten months after the September 11th attacks, eight focus groups were conducted in English with a total of 54 children in the Chinatown community. These participants were recruited from two daycare programs run by Chinese-American Planning Council. (See Appendix A for the research methodology.)

"My mom told me not to talk about [the 9/11 attacks] anymore and forget it... I think I will forget, but it's hard. It was a big thing."

a. **Participant Profile**

The children, ranging in age from seven to ten, attended school at P.S. 124 and P.S. 130. All of the children were from immigrant families, and Chinese is the primary language spoken in the household. Two-thirds of the children's parents worked in Chinatown's garment and restaurant industries.

b. **Findings**

The focus groups, lasting 30 to 45 minutes each, uncovered the stories of the fears and worries of these children, who experienced the chaotic aftermath of the attacks; their awareness of the adverse impact of September 11th on their family's economic and psychological well-being; and their attempts to make sense of and cope with the terrifying information that they had been exposed to.

i. **Experience of September 11th:**

"I saw the Twin Towers; it was like a volcano - lots of smoke coming out of the top!"

- Attending school in close proximity to the disaster area. All the children were in school when the September 11th attacks occurred. They recalled the commotion at school and getting sketchy information about what had happened. Some of them saw the Twin Towers on fire as they looked out of their classroom windows.
- Waiting to be picked up at school. Many of the children became anxious as they awaited the arrival of their parents, who they assumed would have a hard time leaving their work and might not even have heard about the school closings because of language barriers.
- Walking home and witnessing the chaos in the streets. All the children walked home with the crowds evacuating from the Financial District amidst the smoke and foul odor. Some of the children who lived outside the Chinatown area had to walk several miles across area bridges to get home.

⁵⁵ United Way of New York City, 2002.

- Watching details of the September 11th attacks on television. The majority of the children spent hours watching uncensored and disturbing details about the attacks.
- Normalcy of life severely affected. The children who lived in Chinatown were confined to their apartments for several days as a result of tight security in the neighborhood and the closing of businesses. While their schools remained closed for an entire week, they had to cope with the foul odor emanating from the collapsed Twin Towers and the disruption of utility services in their apartments.

ii. **Reactions to September 11th attacks:**

"I was walking across the bridge to get home, and I was worried that they might bomb the bridge."

- Fears and anxieties. All the children acknowledged that they were "frightened" and "scared" by the extent of violence and destruction they witnessed in the September 11th attacks, and they worried about whether similar calamities might happen to them and their families.
- Overwhelming sadness. All the children expressed tremendous sadness and concern regarding the large number of casualties incurred in the September 11th attacks. The deaths of firemen and policemen, who were hero icons in the neighborhood, made the loss feel closer to home and severely undermined the children's sense of security.
- Nightmares. Half of the children reported having nightmares in the weeks after the September 11th attacks. The content of all the nightmares centered around the theme of the children and/or their family members becoming victims of disasters similar to the September 11th attacks.

iii. **Current Mental Health Issues:**

"I didn't tell my parents about my bad dream, because I think they are going to get angry at me...because [the 9/11 attacks] already passed and they don't want to talk about it."

- Continued concerns about safety. All of the children expressed varying degrees of worry about continued threats of terrorism. Some of them revealed that they still had occasional nightmares about their personal safety. Some worried about their family members and the dangers of commuting to work.
- Anxieties due to increased parental worries and tensions in the family after September 11th. Children noticed that their parents were generally worried about the economy in Chinatown and the issue of safety in the city, and as a result, the children became more anxious about the stability of their lives.
- Unable to get clarification and reassurance regarding fears and worries. Most of the children have tried not to think or talk about their worries. There seems to be some tacit understanding that their parents already have enough of their own worries, and that they may not be able to understand their children's perspectives because of language and generational differences.
- Overall sense of loss that there is a decline in the quality of their lives. Most of the children expressed sadness that their family's lives have been adversely affected in many ways by the September 11th attacks.

iv. **Coping mechanisms:**

- Attempting to cope with stress on their own. The majority of children claimed that they generally did not go to their parents when they were upset, except for serious squabbles with their siblings. They also did not feel that they could go to

their teachers with their worries, because they represent authority figures to them. In the Asian culture, those in authority are to be given particular deference and modesty is highly valued, especially when one is relating to a superior or authority figure. These cultural traits render the expression of one's troubles inappropriate, burdensome and/or shameful. The children generally coped with stress by using different activities to distract them from troublesome thoughts.

2. **Elderly**

In July 2002, ten months after the tragedy of September 11th, five focus groups were conducted in Chinese with a total of 51 Chinese American senior citizens. These participants were recruited from three senior citizen centers in the Chinatown community: City Hall Senior Center, Knickerbocker Village Senior Center, and Project Open Door. (See Appendix A for the research methodology.)

"The next morning, I felt severe pains in my chest and heaviness in my heart – something I never experienced before."

a. **Participant Profile**

The participants ranged in age from their early sixties to mid-seventies, and the gender ratio was approximately 70% females. Half of the participants have lived in the U.S. for forty years or more, but only 25% of the participants felt confident about their command of English. Nearly half of the participants lived alone.

b. **Findings**

The focus groups, lasting approximately an hour each, captured the stories of the elderly who witnessed the horrors of the tragedy, their experiences in a community filled with chaos and disruptions, their attempts to cope with trauma-related stress symptoms, and their feelings of a tremendous sense of loss and vulnerability. These experiences, compounded by issues related to their age, physical frailty, and immigrant and cultural background, presented a compelling picture of an ethnic population in New York City that has been deeply affected on many levels by the World Trade Center disaster.

i. **Traumatic experience of September 11th:**

"I lived through many wars when I was growing up, but never had I run for my life like this time - it was like the end of the world."

- **Direct experience of September 11th attacks.** All of the participants experienced the sights and sounds of the plane attacks on the morning of September 11th because of their close proximity to the World Trade Center. Nearly half of them witnessed the second plane attack and/or the collapse of the Twin Towers from the streets and windows of their apartments.
- **Evacuation in the streets.** Many of the participants had the harrowing experience of evacuating with the crowds from the Financial District amidst the choking smoke, dust and debris.
- **Inability to return home.** Many of the participants could not return home right away because of blocked streets and police activity.
- **Worries about family members.** Nearly one-third of the participants had children and other close family members who worked in the World Trade Center area. Worries about their safety were heightened by the loss of phone lines in the neighborhood and their inability to access information about the disaster due to their language barriers.

ii. Continued trauma after September 11th:

"I live alone, and the phone went dead. I lost contact with the outside world, and I was very frightened."

- Living in isolation. Most of the participants were confined in their apartments during the first week after September 11th due to the imposition of the "frozen zone" in the area and tight police surveillance in the neighborhood. Sporadic contacts with their families perpetuated their worries and fears.
- Poor living conditions. All of the participants' living conditions were severely affected for some time due to telephone service disruptions and the lingering foul odor from the explosions and collapse of the Twin Towers.
- Post-traumatic stress symptoms and worsening of health conditions. Shortly after the tragedy, all of the participants complained of one or more post-traumatic stress symptoms, including insomnia, nightmares, loss of appetite, respiratory ailments, rapid heartbeat, general nervousness, recurrent thoughts, and flashbacks of their experience on September 11th. Several participants had to seek medical help for deteriorating heart conditions and other health concerns.

iii. Current mental health issues:

"WTC was a landmark to me. I saw it everyday. Now it is gone, and it has affected me greatly. I have lived in NYC for over 40 years. I witnessed the construction and opening of WTC. I live alone. Before the disaster, I used to go and sit in front of WTC almost everyday. I felt very close to WTC. Now whenever I read the news about the disaster and hear the National Anthem, I cannot hold back my tears. It is more sadness than fear... I am not afraid to die - I am just very sad."

- Post-traumatic stress symptoms. Nearly half of the participants continued to suffer from one or more aforementioned post-traumatic stress symptoms. Insomnia, weight loss, and curtailing of social activities were the major manifestations of the participants' affected mental status.
- Grief and sense of loss from the attack on the Twin Towers. The participants expressed a great deal of sadness regarding the loss of the Twin Towers. Many of them witnessed the construction and the opening of the Twin Towers, and all of them regarded the Towers and the adjacent area as a haven in their neighborhood and an intimate part of their lives. For many of them, the collapse of the Twin Towers triggered a sense of loss associated with aging and their immigration experiences. During the focus group sessions, some participants exhibited depressive symptoms of crying, sad affects, and ruminations of being old and alone.
- Sense of hopelessness and helplessness. All the participants expressed sentiments of disillusionment that their immigrant dream of finding peace and security in America had been undermined by the September 11th attacks. Coupled with the realities of their lack of mobility and frailty due to old age and their immigrant status, participants possessed a heightened sense of hopelessness and helplessness regarding their lives and the future.

iv. Coping mechanisms:

"Our children have their own lives, and it is hard for them to understand how the older generation feels... You wouldn't want them to worry about you... We seniors need to come to the Center to make friends, to socialize, and help each other out."

- Utilization of senior center services. All the participants attributed their varying degrees of recovery from the September 11th trauma to the support network and the sense of purpose and structure afforded by the senior centers.
- Support from peers. All of the participants perceived their peers to be their primary source of emotional support, even though they view their ties with their children as their most important concern. They generally felt that it was difficult for their children to relate to their lives and feelings, and they also believed that they should not burden their children with their worries.
- Cultural beliefs. All of the participants subscribed to the Asian cultural beliefs that personal problems and feelings are private matters that should not be divulged to strangers, and that avoidance of thoughts through activity is the best antidote to cope with one's worries, grief, and pain.

3. **Dislocated Workers**

In July 2002, ten months after the September 11th attacks, five focus groups were conducted in Chinese with a total of 40 Chinese Americans who became unemployed as a result of shop closings or layoffs after the tragedy. Four groups were held at the Chinatown Manpower Project, and one group was held at the Chinese Christian Herald Crusades. Both are Chinatown-based organizations where participants had enrolled in English classes during their unemployment.

"After 9/11, there was mental stress – then there was stress over finances and stress over dealing with pressure from the family to get a job. Right now, it's hard to tell where the stress is coming from because everything is related."

a. **Profile of Participants**

80% of the participants were female, between the ages of 41-54, and blue-collar workers in the garment and hotel industries. Nearly half of them had been living in the U.S. for over twenty years; however, most of them considered their command of English to be inadequate. Over two-thirds of them were married with children, most of whom were attending college at the time. Nearly half of the spouses of the participants were also not working due to the poor economy and/or health reasons. One-fourth of the participants provided financial support to family members overseas.

b. **Findings**

The focus groups, lasting an hour each, captured the stories of a group of working-class immigrants who were faced with the grim prospect of not being able to support their families for the first time since their immigration to the U.S. many years ago. Their accounts of stressful experiences included the trauma of witnessing the WTC attacks, the huge transition to having a lot of free time, and facing the cultural stigma of being unproductive among family members and peers. Worst of all was the humiliating experience of searching for jobs against the stark reality that their age, gender, lack of job skills and poor command of English placed them at a severe disadvantage in a competitive job market.

i. **The experience of September 11th:**

"After 9/11, I get scared whenever I hear the roaring sounds of airplanes or see planes flying."

- Direct experience of September 11th attacks. Almost half of the participants witnessed the plane attacks and/or collapse of the Twin Towers due to the close proximity of their work sites. For several of the participants who worked next door to or across from the World Trade Center, the experience of evacuating their jobs was particularly traumatic.

ii. The experience of unemployment:

"It is difficult for women who don't speak English to find jobs outside the garment industry - especially if you are older."

- First major unemployment episode. All of the participants had a long history of steady employment. Half of them were laid off for the first time, while others stated this was their longest period of unemployment.
- Futile search for a job. As immigrants lacking credentials for employment and adequate commands of English, most of the participants had to confine their employment search to the Chinese American community. However, job opportunities that were compatible with the participants' background and skills were limited due to the declining economy after September 11th. Older female participants who had always worked in the garment industry realized that they could not compete with younger workers who had more job skills and were willing to accept lower wages.
- Frustrating experience of applying for government benefits. Many of the participants encountered bureaucratic delays and unsympathetic staff during the application process for government benefits. Participants believed that their inadequate command of English and their ethnic minority status were major obstacles to receiving assistance and services.

iii. Current mental health issues:

"There is a huge invisible pressure weighing on us...We have to pay the bills. Nothing can be more important than that...The stress is becoming worse. I am very anxious."

- Post-traumatic stress symptoms. Several participants reported experiencing post-traumatic stress symptoms, which included recurrent nightmares and flashbacks of the sights, sounds and smells of the September 11th attacks; feeling fearful of crowds; and becoming hyper-vigilant easily.
- Related stress symptoms due to unemployment. All of the participants were not hopeful of finding a job in the near future, and they worried about their financial stability once they depleted their savings. All of them acknowledged that they had been experiencing a tremendous amount of stress, manifested in headaches, body aches and pains, loss of appetite and weight, poor memory and concentration, and hair loss. Two-thirds of them reported that they suffered from sleep disturbance.
- Mounting tensions and conflicts in their family relationships. Most of the participants acknowledged that their relationships with their spouses had been strained during their unemployment period. Many of them felt they were being blamed when their spouses expressed concerns regarding their unemployment.
- Social isolation. Due to a lack of financial resources, ongoing terrorist threats, and preoccupations with unemployment-related issues, all of the participants curtailed their social activities.

iv. Coping mechanisms:

"If I wasn't able to enroll in the training classes, I don't know what I would have done with my time...I probably would be worrying more about not having a job."

- Attempts to be productive with their time. All of the participants kept themselves busy by attending job-training classes three to five days a week. A few of them also signed up for volunteer work in a local hospital. In accordance with Asian cultural ideals that place premium value on work, these programs enabled them

to feel that they were not idling, and that the time they spent studying was an investment in their future.

- Seeking concrete solutions. All of the participants wanted to be able to take some action to address their unemployment predicament. They did not believe that discussing their stress with a mental health professional would be effective in alleviating their anxiety and worries.

C. Prevalence of Mental Health Issues in Community

The focus group findings were reinforced by a survey of 11 mental health and 38 social service providers from the Chinese Community Social Services and Health Council and a series of interviews and focus groups with a total of 25 mental health program administrators and service providers from five major mental health facilities that serve the Chinatown community. Surveys, interviews, and focus groups were conducted between July 2002 and October 2002⁵⁶. Of the social service providers⁵⁷, 26 provide services to children and families; 12 provide services to the elderly; and one provides services to dislocated workers.

Stress symptoms among existing clientele of mental health facilities

- Clients who were older immigrants, refugees, had experienced war, or had experienced other traumas showed symptoms of retraumatization.
- Clients who were undocumented immigrants exhibited more anxiety about their future in the United States.
- Other clients showed varying degrees of increased depression, anxiety, hyper-vigilant behavior, and insomnia due to safety and financial concerns.

Impressions of Chinatown's social service providers

- About one-third of service providers reported an increase in the number of Asian clients seeking social services (non-mental health services) in the first three months after September 11th and in the first six months of 2002, compared to baseline levels prior to September 11th.
- Worries over financial resources and medical benefits were common. In the first three months after September 11th, over half of the respondents (57%) indicated that their clients were predominantly interested in seeking financial and/or unemployment assistance.
- Social service providers noted anxiety and depressive symptoms, somatic problems, and family conflicts as major complaints among clients.
- Among responding social service providers, approximately one-third of clients reported that young children in the family occasionally or frequently exhibited fearful reactions in the three months after September 11th (36%) and in the first six months of 2002 (38%).
- Similarly, responding social service providers estimated that approximately four out of ten of their clients reported that they had older parents who were exhibiting fearful reactions.
- According to survey respondents, the incidence of expressed or observed client difficulties generally increased over time. In comparing the first three months after September 11th to the first six months of 2002:
 - The incidence of medical problems as a presenting problem grew significantly, from 17% to 44% of respondents, respectively.
 - The incidence of family problems grew from 13% to 31% of respondents,

⁵⁶ At the time of the survey, all of the surveyed social service and mental health service organizations were serving the Chinatown community.

⁵⁷ Agencies may provide services to more than one population. The range of populations served is children/adolescents, families, new immigrants/refugees, elderly, physically/mentally disabled, substance and alcohol abusers.

respectively.

- 50% of respondents indicated that their clients raised concerns about their physical health more frequently in the first half of 2002.
- Over 60% of the respondents indicated that mental health symptoms were discussed more often in the first half of 2002.
- 37% of respondents indicated that their clients' young children exhibited fearful reactions more frequently in the first half of 2002.
- Approximately 40% of respondents indicated that clients' older parents expressed fearful reactions more frequently in the first half of 2002.
- Consistent with findings from the Federation's economic impact study⁵⁸, surveys indicated that an estimated 25% of the residents in Chinatown were still affected by the attacks of September 11th, due to direct exposure to the trauma and massive unemployment in the neighborhood. The elderly, children, the mentally ill, and those living alone were identified as vulnerable populations who were most impacted by the September 11th attacks.
- Almost all respondents believed that a substantial number of Asians were, at the time of the survey, still affected by September 11th with respect to their finances (89% of respondents answered affirmatively), mental health (53%), family relationships (45%) and physical health (18%).
- Social service providers regarded the greatest barriers to mental health access for their clients as: language barriers (84% of respondents answered affirmatively) and lack of information about resources (82%). Conflicts with busy work schedule, stigma associated with seeking assistance, and fear of using government services due to immigration status were also cited as hindrances.
- The majority of responding agencies (61% of respondents) did not believe that adequate resources exist to meet the needs of those affected by September 11th, nor did most feel that their organizations were sufficiently equipped to help the community cope with the aftermath (87%).
- Most respondents felt that they needed more training to adequately assess their clients' mental health needs (84% of respondents answered affirmatively) and to provide special assistance for traumatized victims (82%).

D. Quantitative Findings: Project Liberty Data

Similar to the research methodology for victims' families, a quantitative assessment of service utilization data was implemented to provide a framework for understanding mental health impacts at the community level. The research team conducted an analysis of service utilization data from Project Liberty, a federally⁵⁹-funded crisis counseling, public education, and mental health outreach program for New Yorkers affected by the World Trade Center attack. As mentioned in Chapter 1, Project Liberty operates through over 70 community-based providers in New York City, including mental health agencies and hospitals. Outreach and assessments are conducted in the community, in locations such as schools, community centers, work sites, individuals' homes, and places of worship. For the purposes of this study, assessment forms from the Project Liberty program operating through Hamilton-Madison House, the largest provider of mental health services to the Chinatown and Asian American communities in New York City, were analyzed. As in the case of the victims' families, the Project Liberty data add another dimension of understanding to the experiences of the three Chinatown populations and are useful for reinforcing or refuting the findings derived in the focus groups. As such, they have implications for informing mental health policy and program planning for these groups.

⁵⁸ *Chinatown After September 11th: An Economic Impact Study*, Asian American Federation (April 2002). This report found that one-quarter of Chinatown's workforce lost jobs in the first three months after September 11th.

⁵⁹ Federal Emergency Management Agency (FEMA).

Project Liberty: Hamilton-Madison House Data

As documented in Chapter One, in the year after September 11th ⁶⁰, Hamilton-Madison House assessed 13,859 individuals through its Project Liberty program. The majority, 68.8% (9,538), of the individuals assessed were Asian or Pacific Islander (API). Moreover, the majority, 79.2% (7,551), of the APIs assessed were individuals who identified as Chinese-speakers.

Within the four ZIP codes that comprise Chinatown (10002, 10003, 10012, 10038), a total of 4,798 assessments were completed in the year⁶¹ following September 11th. The following is a presentation of key findings from analyses of assessments of: 1) Children (Ages 6-11), 2) Older Adults (Age 55+)⁶² and 3) Displaced Employed and Unemployed Workers in this area. Project Liberty assessments document a spectrum of indicators of mental health status for assessed individuals in each of the following categories: i) Behavioral Reactions,⁶³ ii) Emotional Reactions,⁶⁴ iii) Physical Reactions,⁶⁵ and iv) Cognitive Reactions⁶⁶. The employed mode of analysis is purely descriptive; a causal relationship between variables is not implied. All of the reactions documented were current or visible at the time of the assessment.

It should be noted that caution should be employed in interpreting these findings; the data represent solely the sample of Chinatown populations assessed by Project Liberty/Hamilton-Madison House and are neither necessarily generalizable to the entire population of Chinatown populations nor to the entire population of Project Liberty clients. While Hamilton-Madison House is the largest Project Liberty provider to Asian Americans, other programs contracted with Project Liberty also serve Asian Americans (See Chapter 3 for a listing of these programs).

1. Children (Ages 6-11)

During the year after September 11th, 122 API children, between the ages of 6 and 11, were assessed within the Chinatown ZIP codes. Approximately half (60) of these children were male, while 51% (62) were female. Over half (55.74%) of Chinatown children were suffering from sadness and/or tearfulness, and nearly one-fifth (17.21%) were experiencing anxiety and/or fear. In comparison to other API children and children from the total sample population⁶⁷ in New York City, API children in Chinatown suffered more isolation and/or withdrawal, sadness and/or tearfulness, despair and/or hopelessness, difficulty falling or staying asleep, and stomach problems in the year after September 11th. Moreover, it was evident that expressions of specific categories of reactions correlated with gender; boys expressed higher levels of behavioral and cognitive reactions, while girls demonstrated more emotional reactions.

⁶⁰ Program commenced October 2001; data reflect period of October 2001-September 30, 2002.

⁶¹ Small sample size and the nature of outreach limit a substantive analysis on temporal variation of reactions.

⁶² An age classification for Elderly (Age 65+) was not available on the assessment form.

⁶³ **Behavioral Reactions:** 1) Extreme changes in activity level; 2) Excessive use of drugs, alcohol, or prescription drugs; 3) Isolation/withdrawal; 4) Hyper vigilance; 5) Reluctance to leave home; 6) Violent behavior; 7) Other; 8) None; 9) Unknown.

⁶⁴ **Emotional Reactions:** 1) Sadness, tearfulness; 2) Irritability, anger; 3) Feels anxious, fearful; 4) Despair, hopeless; 5) Feels guilty/shameful; 6) Feels emotionally numb, disconnected; 7) Other; 8) None; 9) Unknown.

⁶⁵ **Physical Reactions:** 1) Headaches; 2) Stomach problems; 3) Difficulty falling or staying asleep; 4) Difficulty eating; 5) Worsening of chronic health conditions; 6) Fatigue/exhaustion; 7) Chronic agitation; 8) Other; 9) None; 10) Unknown.

⁶⁶ **Cognitive Reactions:** 1) Inability to accept/cope with death of loved one(s); 2) Distressing dreams; 3) Intrusive thoughts or images; 4) Difficulty concentrating; 5) Difficulty remembering things; 6) Difficulty making decisions; 7) Preoccupation with death; 8) Suicidal thoughts or feelings; 9) Other; 10) None; 11) Unknown

⁶⁷ All data is from Hamilton-Madison House/Project Liberty. The total sample population represented is all 13,859 individuals (Asian and Non-Asian) assessed by this program from October 2001 through September 30, 2002. Special emphasis should be placed on the fact that the total sample population is specifically the universe of individuals assessed by Hamilton-Madison House/Project Liberty in New York City and is not a sample necessarily reflective of the entire New York City population.

Behavioral Reactions: *One-quarter (25.4%) of the children assessed in Chinatown expressed one or more behavioral reactions.*

- Nearly one in eleven Chinatown children (9.0%) were experiencing isolation and/or withdrawal at the time of the assessment.
- A greater proportion of children in Chinatown experienced isolation and/or withdrawal (9.0%) than the total sample of children (6.5%) and the total sample of API children (7.5%).
 - This difference is attributed to the large proportion of boys who experienced this reaction (11.7%).

Cognitive Reactions: *Nearly one in five children assessed in Chinatown (19.7%) expressed one or more cognitive reactions.*

- More than one in nine Chinatown children (11.5%) experienced distressing dreams.
- A greater proportion of Chinatown boys (13.3%) experienced distressing dreams than the total sample of API children (11.9%).
- A greater proportion of Chinatown boys (11.7%) experienced intrusive thoughts and/or images than the total sample of children (9.7%) and the total sample of API children (9.4%).

Emotional Reactions: *Almost three-quarters (72.1%) of the children assessed in Chinatown indicated one or more emotional reactions.*

- More than half of these Chinatown children (55.7%) expressed sadness and/or tearfulness.
- More than one in six Chinatown children (17.2%) were assessed as anxious and/or fearful.
- A greater proportion of Chinatown children (55.7%) experienced sadness/tearfulness than the total sample of children (53.8%).
 - This difference is attributed to a higher level of this reaction in girls (66.1%).

Physical Reactions: *More than one in ten (12.3%) of the children assessed in Chinatown indicated one or more physical reactions.*

- Nearly one in eleven (9.0%) Chinatown children experienced difficulty falling asleep.
- A greater proportion of Chinatown girls experienced difficulty falling or staying asleep than the total sample of API children and children in the total sample population (11.3%, 8.1%, 8.6%, respectively).
- A greater proportion of Chinatown boys (5%) experienced stomach problems than the total sample of Asian American children (3.8%) and children in the total sample population (3.2%).

2. **Older Adults (Age 55+)**

A total of 1,813 API older adults, age 55 and over, were assessed in the Chinatown ZIP codes during this timeframe. Of these individuals, approximately 44% (797) were male, and 56% (1,016) were female. Over half (53.5%) of the older adults in Chinatown suffered sadness and/or tearfulness; 42.5% experienced anxiety and/or fear; nearly one-quarter (24.5%) had trouble falling and/or staying asleep; and one in five (19%) expressed irritability and/or anger. Compared to other API older adults and the total sample population in New York City, the API older adult population in Chinatown suffered from more sadness/tearfulness and a greater degree of worsening of chronic health conditions. Differences between these groups are more pronounced when gender is isolated. For example, in comparison with other Asian American older adults and the total sample population of older adults in New York City, older adult women in Chinatown experienced more distressing dreams, difficulty concentrating, and anxiety/fear, while men suffered more irritability/anger and despair/hopelessness.

Behavioral Reactions: *Forty percent (40.6%) of Chinatown older adults indicated one or more behavioral reactions.*

- Approximately one in ten older adults in Chinatown expressed:
 - Hyper-vigilance (13.4%)
 - Reluctance to leave home (11.3%)
 - Extreme changes in activity levels (9.8%)

Cognitive Reactions: *Nearly nine out of ten (86.4%) older adults experienced one or more cognitive reactions.*

- Approximately one in ten older adult women in Chinatown experienced distressing dreams (11.6%) and intrusive thoughts and/or images (9.1%).
 - The incidence of distressing dreams for older adult women in Chinatown represents a greater proportion than that for both Asian American older adults (9.4%.) and older adults in the total sample population (9.3%).
 - The incidence of intrusive thoughts for older adult women in Chinatown represents a greater proportion than that for Asian American older adults in the total sample population (7.5%).

Emotional Reactions: *Nearly all of Chinatown's older adults (97.4%) indicated one or more emotional reactions.*

- Over half of the older adults assessed in Chinatown (53.5%) experienced sadness and/or tearfulness.
- 42.5% experienced anxiety/fearfulness.
- One in five (19%) indicated irritability and/or anger.
- More than one in eight (13.2%) indicated despair and/or hopelessness.
- A greater proportion of API older adults in Chinatown (53.5%) experienced more sadness and/or tearfulness than API older adults (50.3%) and older adults in the total sample population (50.3%).
 - This difference is attributed to the greater proportion of older adult women (61%) in Chinatown who experienced sadness and/or tearfulness.
- A greater proportion of older adult men in Chinatown (27.5%) experienced more irritability and/or anger than both older adult APIs (20.9%) and older adults in total sample population (23.2%).
- A greater proportion of older adult men in Chinatown (15.2%) experienced more despair and/or hopelessness than older adult APIs in the total sample population (13.2%).
- A greater proportion of older adult women in Chinatown expressed higher levels of anxiety and/or fear (44.1%) than both older adults APIs (41%) and older adults in the total sample population (42.9%).

Physical Reactions: *Almost nine out of ten (88.4%) older adults in Chinatown indicated one or more physical reactions.*

- Nearly one-quarter (24.5%) of the older adults in Chinatown experienced difficulty falling or staying asleep.
- Over 10% of the older adults in Chinatown experienced worsening of chronic health conditions (13%) and headaches (12.1%).
- A greater proportion of API older adult women in Chinatown (10.9%) experienced difficulty eating than older adults in the total sample population (7.6%).
- A greater proportion of older adult API women in Chinatown (14.8%) experienced worsening of chronic health conditions than API older adults in the total sample population (11.5%).
- A greater proportion of older adult women in Chinatown (28.7%) experienced difficulty falling or staying asleep than older adults in the total sample population (24.4%).

3. **Dislocated Workers**

A total of 445 API dislocated workers were assessed in the Chinatown ZIP codes during this time period. Of these individuals, 46% (203) were male, and 54% (242) were female. Over half of the assessed dislocated workers in Chinatown experienced anxiety/fear (55.1%) and sadness/tearfulness (51.7%). In addition, over one-quarter of Chinatown's assessed dislocated worker population experienced irritability/anger (28.1%) and despair/hopelessness (25.4%). Nearly one-third had difficulty falling or staying asleep, (31%) and one in five (21.8%) suffered from headaches. Compared to dislocated workers in New York City (other API dislocated workers and dislocated workers in the total sample population), a greater proportion of the Chinatown dislocated worker population suffered extensively from emotional and physical reactions.

Behavioral Reactions: *Over 40% (42.3%) of dislocated workers in Chinatown experienced one or more behavioral reactions.*

- Approximately one in ten API dislocated workers in Chinatown experienced:
 - Reluctance to leave home (12.1%)
 - Extreme changes in activity levels (11.9%)
 - Hyper-vigilance (10.8%)
 - Isolation/withdrawal (9.4%)
- A greater proportion of Chinatown API dislocated workers experienced hyper-vigilance (10.8%) than API dislocated workers in the total sample population (8.4%).
 - This difference is attributed to the greater proportion of Chinatown API female dislocated workers (12.8%) who experienced hyper-vigilance.
- A greater proportion of dislocated workers in Chinatown experienced extreme changes in activity level (11.9%) than API dislocated workers (8.9%) and dislocated workers in the total sample population (9.7%).
- A greater proportion of male dislocated workers in Chinatown (13.8%) experienced isolation and withdrawal than API dislocated workers in the total sample population (11.8%).
- A greater proportion of female dislocated workers in Chinatown (16.1%) experienced reluctance to leave home than API dislocated workers (13.4%) and dislocated workers in the total sample population (13.6%).

Cognitive Reactions: *Forty percent (40.2%) of Chinatown workers expressed one or more cognitive reactions.*

- Nearly one in seven (14%) API dislocated workers in Chinatown experienced difficulty making decisions.
- A greater proportion of female API dislocated workers in Chinatown (7.1%) experienced difficulty remembering things than dislocated workers in the total sample population (5.9%).

Emotional Reactions: *Nearly all (97.5%) of Chinatown's dislocated workers experienced one or more emotional reactions.*

- Over half of Chinatown dislocated workers indicated:
 - Anxiety and/or fear (55.1%)
 - Sadness and/or tearfulness (51.7%)
- Over one-quarter of Chinatown dislocated workers expressed:
 - Irritability and/or anger (28.1%)
 - Despair and/or hopelessness (25.4%)
- A greater proportion of API dislocated workers in Chinatown experienced the following reactions than API dislocated workers and dislocated workers in the total sample population:
 - Anxiety/Fear (55.1%, 52.6%, and 49.3%, respectively). This difference is attributed to the greater proportion of female dislocated workers with this reaction (74.4%).

- Sadness/Tearfulness (51.7%, 37.9%, and 38.5%).
- Irritability/Anger (28.1%, 23%, and 24.1%). This difference is attributed to the greater proportion of female dislocated workers with this reaction (74.4%).
- Despair/Hopelessness (25.4%, 20.4%, and 20.6%).
- Female dislocated workers suffered particularly severe emotional reactions; three-quarters (74.38%) of all women in Chinatown who were dislocated workers expressed anxiety and/or fear.

Physical Reactions: *Nearly 70% (66.29%) of Chinatown dislocated workers suffered from one or more physical reactions.*

- 31% of API dislocated workers in Chinatown experienced difficulty falling or staying asleep.
- One in five (21.8%) experienced headaches.
- More than one in ten experienced:
 - Fatigue and/or exhaustion (12.6%)
 - Difficulty eating (11.7%)
- A greater proportion of API dislocated workers in Chinatown experienced the following reactions than API dislocated workers and dislocated workers in the total sample population:
 - Difficulty falling or staying asleep (31%, 28.1%, and 27.2%, respectively)
 - Headaches (21.8%, 14.6%, and 13.7%)
 - Difficulty eating (11.7%, 9.8%, and 8.9%)
- A greater proportion of female dislocated workers in Chinatown (16.5%) experienced fatigue and/or exhaustion than dislocated workers in the total sample population (14.6%).

The Project Liberty data shows that Asian Americans do suffer some negative mental health outcomes to a greater extent in comparison to the total sample population. This is contrary to much of the literature to date documenting the mental health status of Asian Americans relative to other groups, including research from the New York Academy of Medicine⁶⁸. Even before September 11th, Chinatown residents suffered from a greater-than-average number of life stressors due to their low socioeconomic status. After September 11th, these individuals demonstrated high levels of negative mental health impacts. Moreover, the extent of many of these negative reactions was greater than that of other Asian Americans in the sample population as well as that of the total sample population, due to the neighborhood's proximity to Ground Zero, as well as to the unique vulnerabilities of this community's subgroups.

Overall, the findings from Project Liberty reinforce the themes that were expressed in the focus groups. Participants' responses were heavily imbued with an intense sense of sadness about the losses engendered by the September 11th tragedy. These losses were compounded by excessive anxiety about their own and their family members' physical and financial security. The Project Liberty data illuminate the same reactions in the larger community; more than 50% of each population indicated sadness/tearfulness, and between 20-50% of each group indicated anxiety/fear, making these the most frequently expressed reactions.

The focus groups revealed that children were overwhelmingly saddened by the impact that September 11th had on their families, particularly on their parents, many of whom were dislocated as a result of September 11th. Children expressed a great deal of concern about their parents' employment status and the conflicts that occurred between parents as a result. In the focus groups, some children indicated that they still had nightmares related to their personal safety, a finding corroborated by the Project Liberty data. Specifically, the experience of distressing dreams was the most frequently cited cognitive reaction among

⁶⁸ Galea, et al. (2002)

children, with more than one in ten children reporting these at the time of assessment.

Among the elderly, the September 11th tragedy evoked a sense of loss associated with aging and with the process of immigrating to the U.S. September 11th magnified feelings of insecurity, helplessness, and hopelessness that these participants felt were inherent to their old age and immigrant status. In addition, the elderly focus group participants complained of physical symptoms, such as insomnia and weight loss, regarded as manifestations of September 11th stress. Project Liberty findings detailing the wide extent of reactions, such as difficulty with sleep and difficulty with eating, reinforce the focus group data.

For dislocated workers, anxiety related to their employment status was the prevailing mental health issue. This stress was exhibited physically (e.g., as headaches and loss of appetite) and also had social repercussions (e.g., straining relationships between family members). The Project Liberty findings support this data; the Chinatown dislocated worker population, as compared to other Asian Americans and the total sample population, reported much higher levels of specific physical reactions, including the aforementioned reactions. Women, in particular, were adversely affected by the tragedy; three-quarters of all female dislocated workers represented in the Project Liberty data expressed anxiety/fear.

Summary

On many levels, September 11th crippled Chinatown, an already vulnerable immigrant community beleaguered by a high poverty rate and low levels of citizenship, educational attainment, and English proficiency. As a neighborhood within very close proximity to Ground Zero, Chinatown was dealt severe economic and social blows in the wake of the tragedy. All of the focus group participants in this study witnessed the attacks first-hand or in ways that otherwise fundamentally altered their lives. Nearly a year after September 11th, these particularly vulnerable populations remained in distress, a finding that was reinforced at the community level by the Project Liberty data. Shades of trauma manifested themselves in such forms as nightmares in children and war flashbacks in the elderly. Dislocated workers expressed heightened family tensions as a result of unemployment.

Despite their distress, focus group participants did not utilize mental health services during this time. Furthermore, during focus groups, elderly and children revealed their hesitation to share feelings with their family members. Doing so was considered by both groups to be placing an unnecessary burden on their families. While the elderly felt that they could more comfortably turn to their peers and friends for support, children, on the other hand, generally did not feel comfortable disclosing their feelings to anyone. Like the dislocated workers, their primary coping mechanism was to preoccupy themselves with other things.

For the city of New York, September 11th has raised the profile of mental health issues in the public eye. However, in Chinatown community mental health centers, an increased demand for services has not been seen. This can be explained in several ways: 1) the current system of services or the concept of mental health service use may not be the most relevant or accessible for this population; 2) this community has been preoccupied with getting concrete needs met; and 3) typically, after a crisis, social service use drops. The fact that existing mental health providers maintained the stabilization of their existing clients during this period of crisis speaks to the importance of the role that they play in the community. The next chapter explores the topic of service utilization by the study populations in further detail.

V. Chapter Three: September 11th - Related Mental Health Initiatives, Service Utilization, Unmet Needs, and Service Gaps

In the aftermath of September 11th, a number of public and private initiatives have been implemented to provide various forms of assistance, including mental health support, to affected individuals in New York City and surrounding areas. The immense need for psychological care resulting from this tragedy has heightened public attention paid to mental health issues and raised social acceptance of help-seeking to a degree.

However, the Federation's research reveals that Asian Americans vastly underutilize this assistance. By and large, programs offered are not sufficiently available or relevant to traditionally underserved Asian Americans. It is important to note that many program limitations cited in this report stem from long-standing deficiencies in the mental health system, reflecting persistent barriers to access and a weak mental health infrastructure. Increased needs resulting from September 11th have highlighted and exacerbated these shortcomings, making it imperative for mental health service providers and funders to directly address the specific unfulfilled needs of Asian Americans in the New York metropolitan area.

This chapter serves three purposes. First, it provides an overview of the response from major public and private entities to September 11th-related mental health needs of the entire New York City-area population. Second, it summarizes use of psychological support services by the populations studied, based on quantitative and qualitative data. Finally, it enumerates unmet needs and service gaps identified by study participants and community service providers. Findings described in this chapter form the basis for the policy recommendations set forth in this report.

A. September 11th-Related Mental Health Support

This section provides an overview of the major September 11th-related public and private mental health initiatives that impact Asian American communities. First, it describes the joint mental health program of the American Red Cross and The September 11th Fund. Then, it highlights the role of Mental Health Association/LifeNet in the coordination of service delivery for the major mental health initiatives. Next, it covers three areas of community-based mental health support: 1) the federally-funded Project Liberty crisis counseling, public education, and referral program; 2) September 11th case management programs; and 3) professional mental health services based in non-mental health settings.

1. American Red Cross and The September 11th Fund

The American Red Cross and The September 11th Fund are two of the most visible entities providing various forms of relief assistance in the aftermath of September 11th. From the immediate outset of the crisis, the American Red Cross made mental health services available for affected individuals – specifically, for victims' families, rescue workers, displaced residents, the injured, and economically affected individuals. In August 2002, the American Red Cross and The September 11th Fund launched a joint mental health initiative, providing up to \$3,000 in reimbursement for services⁶⁹ over the expected three to five-year⁷⁰ life of the program, to affected individuals⁷¹.

2. Mental Health Association of New York City/LifeNet

Under contract with the New York City Department of Health and Mental Hygiene, the Mental Health Association sponsors LifeNet, a program that provides public education and outreach, and also operates a 24-hour crisis information and referral hotline. *AYUDESE*, or Spanish LifeNet, and Asian LifeNet are its other-language subsidiaries. Asian LifeNet is staffed by professionals with language capacities in Cantonese, Mandarin, and Korean.

As New York City's largest mental health service network, LifeNet was the only service after September 11th that had an existing communications infrastructure to deal with a crisis of that magnitude. LifeNet serves as the front door in the coordinated response of the major mainstream mental health initiatives. For the American Red Cross and The September 11th Fund program, LifeNet shares the responsibilities of service eligibility determination and referral-making with the American Red Cross⁷². Similarly, Project Liberty designated LifeNet as the major entry point for access to its services⁷³.

3. Project Liberty

Initiated in October 2001⁷⁴ by the Federal Emergency Management Agency (FEMA), Project Liberty provides free short-term crisis counseling, public education, and mental health and other supportive service referrals to those in the New York State area affected by September 11th. As mentioned in earlier chapters, Project Liberty operates

⁶⁹ Services are billable retroactively to September 11, 2001. Eligible clients and licensed mental health service providers may submit claims for reimbursement to The September 11th Fund and the American Red Cross. Only services provided by licensed mental health professionals are reimbursed. Services include outpatient mental health treatment, including individual, group, and family counseling; psychotropic medications; alcohol or substance abuse detoxification, counseling, or outpatient rehabilitation and inpatient hospitalization and/or substance abuse treatment.

⁷⁰ Sharing the costs of the program to maximize resources and streamline relief efforts, the two organizations plan to spend up to \$45-65 million for three to five years from the program start date.

⁷¹ Compared to the American Red Cross, The September 11th Fund reimburses mental health services for a wider range of groups, including injured victims and their family members, former employees of WTC and their family members, dislocated workers who worked in the WTC vicinity and their family members, rescue workers and their family members, displaced residents, and children who attended a nearby school, regardless of income or immigration status.

⁷² As of August 2002.

⁷³ As of the early weeks following September 11th.

⁷⁴ Project Liberty was initiated in October 2001 through a \$22.7 million statewide grant from the Federal Emergency Management Agency (FEMA). New York City received \$14 million to establish Project Liberty counseling services in all five boroughs. In May 2002, FEMA awarded New York State an additional \$112 million to continue the program.

through over 70 community-based providers, including traditional mental health clinics and hospitals. In addition, Project Liberty funds mental health programs in other community settings, such as schools. As of mid-August 2002, Project Liberty had made contact with more than 150,000 individuals who live or work in and around New York City.

With a staff that speaks 22 Asian languages and dialects, Hamilton-Madison House is the largest mental health service provider in New York City's Asian American community. Since October 2001, it has performed extensive outreach for Project Liberty in the New York metropolitan area. In the year after September 11th, Hamilton-Madison House made over 10,000⁷⁵ contacts to Asian American clients in New York City, making it the largest Project Liberty provider to the Asian American community.

Other Project Liberty providers currently serving the Asian American community in Manhattan include Bellevue Hospital, Educational Alliance, Gouverneur Hospital⁷⁶, Henry Street Settlement, Saint Vincent's Hospital, and University Settlement. In the first six months after September 11th, a Project Liberty program was established at the 141 Worth Street FEMA relief center in Manhattan⁷⁷. Outside of Manhattan, Project Liberty operates through community-based service providers in other areas with high concentrations of Asian Americans, such as Flushing, Queens and Sunset Park, Brooklyn.

4. September 11th-Related Case Management

September 11th-related case management services provide a range of assistance and supportive services to affected individuals. In addition to providing and coordinating services, they often serve as the front door for access to mental health information and referrals. Among the major funders of case management services for the Asian American community are the American Red Cross and The September 11th Fund. With the exception of the American Red Cross program, most case management programs operate through community-based social service organizations.

In August 2002, The September 11th Fund expanded its comprehensive case management program to include provision of supportive services to victims' families, the injured, dislocated workers, and displaced residents. Major services include comprehensive needs assessments; provision of information and referrals to mental health counseling and support groups; assistance in accessing legal services, immigration-related services, job training and job placement; assistance with applications; advocacy with service providers; and provision of updates on available services and benefits.

With respect to the Asian American community, this initiative enabled six partner agencies in New York City - Asian American Federation (AAF), Chinatown YMCA, Chinese-American Planning Council (CPC), Filipino American Human Services, Inc. (FAHSI), Japanese American Social Services, Inc. (JASSI), and the New York Asian Women's Center (NYAWC) - to hire bilingual case managers to reach out to and work closely with affected individuals. This partnership is part of United Services Group (USG), a 13-member consortium of community-based organizations throughout New York City that facilitates service coordination and the provision of training for case managers.

Asian American Legal Defense and Education Fund (AALDEF), Asian Americans for Equality (AAFE), Pragati, South Asian Council for Social Services (SACSS), and Young

⁷⁵ Can include follow-up visits.

⁷⁶ From September 12, 2001 to October 2002, Gouverneur conducted approximately 80 intakes with Asian Americans.

⁷⁷ From October 2001 to January 2002, the FEMA Center at 141 Worth Street conducted 120 Project Liberty intakes with Asian Americans. The Project Liberty program at this relief site closed after January 2002.

Korean American Service and Education Center (YKASEC) are other Asian American community-based organizations with case management programs that serve in similar capacities. Please see Appendix B for more information about these individual programs.

5. Professional Mental Health Services in Non-Mental Health Settings

After September 11th, some organizations and institutions that traditionally have not provided mental health services have received funding to employ mental health professionals. The location of these services - outside a traditional clinical setting - decreases the stigma associated with mental health service use. Moreover, the familiarity that community members already have with these organizations facilitates the linkage of more individuals to needed help.

a. Victims' Families

Social Service Setting

Filipino American Human Services, inc. (FAHSI) and South Asian Council for Social Services (SACSS) are two Asian American community organizations that have the capacity to directly provide professional mental health services to September 11th - impacted case management clients. FAHSI employs one bilingual in-house psychiatrist, to whom some mental health referrals are made. Other referrals are made to outside mental health providers, including Project Liberty, Safe Horizon, and Choice Mental Health Center (Woodside, Queens). SACSS employs seven bilingual licensed mental health professionals (1 psychiatrist, six social workers)⁷⁸.

b. Chinatown

School Setting

On September 19, 2002, The September 11th Fund launched a mental health program targeting an estimated 25,000 pre-school through high school-age students who experienced the terrorist attacks first-hand or were traumatized by the subsequent evacuation or relocation from their schools. Under this \$10 to \$15 million initiative, the Fund augments mental health services, providing art therapy, enrichment activities such as summer school and after-school programs, academic preparation assistance, and professional development to help train teachers and others to identify and respond to mental health problems in children. Community School District 2 and School Arts Rescue Initiative Project are among the major grant recipients of this initiative.

Also, in March 2003, \$33 million in Project Liberty aid for downtown schools was allocated to New York City's Department of Education. In Chinatown schools, Saint Vincent's Hospital, in partnership with Project Liberty and the New York City Department of Education, has been screening children and employs Chinese-speaking social workers to work with their parents.

Afterschool and Childcare Centers

In October 2002, the Coalition for Asian American Children and Families (CACF) implemented the CORE initiative (Children Overcoming Through Resources and Education), with the aim of fostering positive mental health outcomes for children and families primarily in Community School Districts 1 and 2. Through community-based events featuring educational and recreational activities that promote coping and healing, the program's preventive, holistic framework emphasizes themes of positive identity, re-establishing normalcy and a sense of safety, pro-social behavior, developing relationships, and community-building. This initiative includes

⁷⁸ As of March 2003. Languages spoken by staff are: Bengali, English, Gujarati, Hindi, and Malayalam.

an extensive public education campaign providing mental health education for parents. It is also developing culturally competent mental health curricula and offers training for community-based service providers.

Church Setting

Since December 12, 2002, the Lutheran Family and Community Services' New Life Center, part of the True Light Lutheran Church, has been providing social service and mental health assistance to the dislocated Fujianese, a more recently immigrated Chinese population. Undocumented status frequently prevents these individuals from seeking much-needed services. Personal intimidation and/or an actual lack of access associated with their circumstances can pose significant barriers. Treatment-seeking, if any, is often delayed until individuals have suffered more severe symptoms of mental illness. Thus, if and when they do come forward for mental health treatment, their issues are typically more advanced and difficult to treat.

According to interviews with program administrators and service providers, church-based mental health services are not only more physically accessible, but undocumented individuals have a greater sense of security when using services with this linkage. Earlier and more sustained treatment over time promotes better outcomes overall, including significant preventive effects.

Primary Care Setting

Since 1997, the Charles B. Wang Community Health Center has sponsored the Mental Health Bridge Program, a unique model of primary care and mental health service integration in the Chinese American community. Patients are routinely screened for mental health issues in visits with their general practitioner and can receive professional mental health services in the same setting.

In February 2002, the Center began conducting September 11th-related mental health outreach to Chinatown's elderly and children through radio programs and in public settings, such as schools and street fairs. The program's objective is to educate these groups to deal with post-September 11th trauma and stress.

Senior Center Setting

Asian LifeNet holds regular monthly support and recreational groups with Fujianese seniors at Hamilton-Madison House Knickerbocker Village Senior Center. The group serves as a support network to decrease social isolation. Support group topics include family conflict resolution and stress management.

Social Service Setting

In February 2002, Asian Americans for Equality (AAFE) commenced the Wellness Program, a mental health initiative with a focus on prevention, coping, and maintaining emotional health. Mental health screening, brief counseling, and referrals are offered in conjunction with concrete assistance (e.g., ESL classes, legal assistance) to individuals in Chinatown who were economically disadvantaged or otherwise negatively impacted by September 11th. The link between these services de-stigmatizes the support received for mental health issues. The Wellness Program also offers educational workshops on mental well-being in a Chinatown library.

The variety of programs at once highlights the diverse needs that exist among Chinatown populations, while pointing to the need for coordination of services to maximize limited resources. Funding for these programs is time-limited, generally not extending beyond one year. As such, these programs are fortifying the foundation for a currently weak Asian American mental health infrastructure. The needs that have been

illuminated post-September 11th are inherently long-term; therefore, a response that is less than long-term is inadequate. For more information about these and other community-based initiatives, see Appendix B.

These programs are set in a larger context of mental health service organizations in the Chinatown community, which, while providing much-needed services, have always faced capacity challenges and resource limitations. See Appendix C for a description of these organizations.

B. Service Utilization of Victims' Families

The following is a presentation of key quantitative and qualitative findings on mental health service utilization by victims' families. The findings are derived from analyses of administrative datasets and database reports as well as from interviews with case managers and mental health providers.

Generally, these data indicate an extremely low level of mental health service utilization on the part of victims' family members, reinforcing the finding from study participant interviews that this population is generally not accessing professional help for emotional issues.

1. **American Red Cross:** In the 17 months after September 11th, less than three percent of Asian victims' family members received mental health services through American Red Cross.
 - From September 12, 2001 until February 14, 2003, 315 family members of Asian victims⁷⁹ accessed American Red Cross services.
 - Of these family members, less than three percent (8) accessed mental health benefits.
 - Those who accessed mental health services were of Japanese (4), Indian (1), and Chinese (1) descent.
 - Mental health benefits were utilized in Japan by three individuals.
 - The remaining five individuals utilized benefits locally, in New York and New Jersey.
 - Victims' families of Indian, Chinese, and Japanese backgrounds accessed American Red Cross services⁸⁰ more than other Asian ethnic groups.
 - Less than half (44%) of the victims' families were assigned case managers.
2. **MHA NYC/Asian LifeNet:** According to interviews with LifeNet administrators and hotline staff, few victims' family members have called the hotline⁸¹.
3. **Project Liberty**⁸²: In the year after September 11th, very few referrals were made by Project Liberty for victims' family members, and of these, most were not accepted.

An analysis of the Hamilton-Madison House/Project Liberty data (see Chapter One for more detail) reveals that among the 24 API family members assessed, only five referrals⁸³ were made.

- Of these, two were to mental health services.

⁷⁹ The clients in the American Red Cross database on Asian victims' families are either Asians or had Asian family members who were victims.

⁸⁰ This includes all American Red Cross services, e.g., financial assistance and concrete services.

⁸¹ It should be noted that the caller's possible status as a victim's family member is not routinely screened. More specific data on service utilization by victims' families is not available due to a lack of such records kept by LifeNet.

⁸² The Project Liberty data are from the Hamilton-Madison House dataset (see Chapters 1 and 2) and span the year following September 11, 2001. The total sample population size is 13,859 individuals.

⁸³ More than one referral can be made per individual. Due to database limitations, it is not possible to tell how many individuals received referrals. The total is taken from the forms with this section filled out; actual number may be higher.

- Two were to other Project Liberty services (e.g., public education, group counseling).
- One was to “other social services.”⁸⁴
- For all services, only 11% accepted the referral(s) made.⁸⁵

4. **September 11th - Related Case Management:** Case management clients who received services from non-Asian mental health providers found them to be unhelpful. The topic of mental health was often not fully broached by case managers due to inadequate mental health training.

Interviews were conducted from December 2002 through March 2003 with case managers from AAF, Chinatown YMCA, CPC, FAHSI, JASSI, NYAWC, Pragati, and SACSS. Consistent with findings from the interviews with victims’ family members in this study, case managers reported that:

- Few of the victims’ family members that used services found the sessions helpful. The major reason cited was that services were not provided by professionals with the same cultural background (AAF).
- Most of the victims’ family members that used mental health services did not have a prior history of mental health service utilization (FAHSI).
- There was variation in the extent to which case managers provided mental health information, referrals, and follow-up to victims’ family members. In some programs, it is routine to discuss mental health services. In a greater portion of programs, however, the topic is rarely broached.
- The degree to which the topic is addressed in case management depends on the case manager’s familiarity and comfort level with mental health issues, level of mental health training, knowledge of available resources, and the client’s own comfort level with the subject matter.
- Programs with in-house professional mental health staff tended to have a higher rate of service linkage among their clients.
- Generally, most Asian clients were interested in obtaining concrete assistance before seeking mental health assistance (AAF, Chinatown Y, CPC, JASSI, NYAWC, Pragati, SACSS).
- Asian clients with higher levels of acculturation, education, English language proficiency, and household income were generally more willing to utilize mental health services (FAHSI, NYAWC, SACSS).

5. **Professional Mental Health Services in Non-Mental Health Settings:** A relatively high level of mental health service use among victims’ families was observed with this type of service.

Interviews with FAHSI and SACSS in December 2002 and March 2003 yielded the following findings:

- Compared with the level of professional mental health service use of other case management clients, a higher degree of mental health service utilization was evident among case management clients using services that were:
 - provided in familiar, non-mental health settings;
 - provided in the client’s home;
 - provided by professionals who share the cultural and linguistic background of their clients;

⁸⁴ The top referral sources for “other social services” were: CPC, American Red Cross, FEMA, NYC Human Resource Administration, Legal Aid Society, NYS Department of Unemployment, Safe Horizon, Crime Victims’ Board, Salvation Army, Small Business Administration, Social Security Administration, and Workers’ Compensation Board.

⁸⁵ Due to the method in which information was recorded, inconsistencies exist in the number of referrals made as compared to the total number of referrals accepted and not accepted. This particular finding was derived from a total of nine responses to the question “Referral Accepted?” This total does not correspond to the total number of responses for referrals made, which as documented above, was five for the group.

- recommended by a trusted individual (e.g., family member, friend, social service provider, community members/word-of-mouth).
- As of July 2003, SACCS had served 44 different families. Among these families, between 80 and 100 individuals received mental health counseling from SACCS' in-house professionals.
- Consistent with findings from the interviews with victims' families, SACCS reported that their clients were initially more interested in concrete assistance. As these needs were addressed over time, clients' openness to seeking mental health support increased, fueled by the above factors.
- SACCS observed associations between the client's relationship to the victim and certain patterns of help-seeking:
 - Spouses of victims were more willing to actively use services, particularly group sessions with other spouses whose prior acquaintance they had made through recreational group activities.
 - Parents of victims appeared to be the most emotionally impacted and to prefer individual counseling.

C. Service Utilization of Chinatown Vulnerable Populations

Key findings on the mental health service use of Chinatown's children, elderly, and dislocated workers are presented in this section. Qualitative and quantitative data from September 11th mental health programs serving the Chinatown community were analyzed. These data corroborate major focus group findings that Chinatown populations are not accessing professional help for emotional issues.

1. **Project Liberty⁸⁶: A very low number of mental health referrals were made in the year after September 11th for Chinatown's children, older adults, and dislocated workers. Of these, mental health referrals were made more often for older adults as a group. Acceptance rates for all social services were high for dislocated workers.**

In general, a low level of referrals was made relative to the number of individuals assessed and relative to the amount of emotional stress caused by the tragedy and its aftermath. As a group, Chinatown's dislocated workers received a relatively higher number of referrals. For all three populations, the majority of referrals were to non-mental health or "other social services."⁸⁷ Professional mental health services and other Project Liberty services were referred between 10 to 30% of the time, for those who received referrals. Of the three groups, older adults received the most mental health service referrals. The acceptance rate for referrals was substantially higher among the dislocated workers, as compared to children and older adults. Overall, these findings support that, while mental health issues are prevalent among these populations, low levels of linkages are being made to much-needed services.

An analysis of the Hamilton-Madison House/Project Liberty data (see Chapter Two for more detail) revealed that:

⁸⁶ The Project Liberty data are from the Hamilton-Madison House dataset (see Chapters One and Two) and span the year following September 11th. The total sample population size is 13,859 individuals.

⁸⁷ The top referral sources for "other social services" were: CPC, American Red Cross, FEMA, NYC Human Resources Administration, Legal Aid Society, NYS Department of Unemployment, Safe Horizon, Crime Victims' Board, Salvation Army, Small Business Administration, Social Security Administration, and Workers' Compensation Board.

a. Children

- Among the 122 API children assessed, only eight referrals⁸⁸ were made.
 - Six were to “other social services”.
 - One was to mental health services.
 - One was to other Project Liberty services (e.g., public education, group counseling).
- The rate of referral acceptance for all services was 59% among this group.⁸⁹

b. Older Adults

- Of the 1,813 API older adults assessed, only 150 referrals⁹⁰ were made.
 - Of these, 56% (84) were to “other social services”.
 - Approximately 30% (29.3%, 44) were to professional mental health services.
 - Over ten percent (11.3%, 17) were to other Project Liberty services.
 - Two percent (3) were to substance abuse services.
 - One percent (2) was to other disaster agencies.
- The rate of referral acceptance for all services was 49% among this group.⁹¹

c. Dislocated Workers

- Among the 445 API dislocated workers assessed, 172 referrals were made.
 - Of these, 77% (133) were to other social services.
 - Ten percent (10.5%, 18) were to other Project Liberty services.
 - Another nearly ten percent (9.3%, 16) were to professional mental health services.
 - Nearly two percent (1.7%, 3) were to other disaster agencies.
 - One percent (1.2%, 2) was to substance abuse services.
- The rate of referral acceptance for all services was 79% among this group.⁹²

2. Case Management: Most clients receiving case management are not expressing interest in mental health services, and few mental health referrals are being made.

Most clients are primarily interested in concrete services (AAF, Chinatown YMCA, CPC). According to case managers, anxiety and family conflicts due to the economic situation are the most common mental health issues affecting their clients, many of whom are dislocated workers (Chinatown YMCA). However, few mental health referrals are being made (Chinatown YMCA, CPC).

3. Professional Mental Health Services in Non-Mental Health Settings: These programs have been successfully reaching people and screening them, but many needy Chinatown community members are still not connecting to services.

School Setting

According to Community School District 2, a 20% increase in referrals to mental health services was seen in some Chinatown schools after mental health screening was initiated.

⁸⁸ More than one referral can be made per individual. Due to database limitations, it is not possible to tell how many individuals received referrals. The total is taken from the forms with this section filled out; actual numbers may be higher.

⁸⁹ Due to the method in which information was recorded, inconsistencies exist in the number of referrals made as compared to the total number of referrals accepted and not accepted. This particular finding was derived from a total of 17 responses to the question “Referral Accepted?” This total does not correspond to the total number of responses for referrals made, which as documented above, was eight total for the group.

⁹⁰ The total indicates the number of forms with this section filled out; the actual number may be higher.

⁹¹ This was derived from a total of 233 responses to the question “Referral Accepted?” This total does not correspond to the total number of responses for referrals received.

⁹² This was derived from a total of 164 responses to the question “Referral Accepted?” This total does not correspond to the total number of responses for referrals received.

Afterschool/Childcare Centers

As of July 2003, the CORE program had reached between 75 to 500 children and 85 to 250 parents in each of their monthly community-based events, for a total of 1400 children and 650 parents⁹³.

Church Setting

As of April 2003, the New Life Center had provided counseling to 100 clients.

Primary Care Setting

Charles B. Wang Community Health Center screened 555 residents from the local Chinatown community five months after September 11th.

- The number of mental health contacts increased by 68% post-September 11th in comparison to the same period pre-September 11th⁹⁴.
- The number of mental health patients was 38% higher post-September 11th in comparison to the same period pre-September 11th.
- Mental health service use increased at a greater rate than primary care service use during these periods. The percentage increase in the aforementioned numbers of mental health encounters and mental health patients (68% and 38%, respectively) was higher than the percentage increase in the number of primary care encounters and the number of primary care patients (29% and 36%, respectively).

Social Service Setting

As of December 2002, 1000 people had been screened at the AAFE assistance center. At that time, there were 68 open cases, all of whom had received brief counseling.

4. Asian LifeNet: The overall level of service utilization has not increased significantly after September 11th. Calls to Asian LifeNet generally tend to be more serious in nature, as compared to calls made to other LifeNet telephone lines.

- While general LifeNet service utilization has greatly increased after September 11th, the level of Asian LifeNet service utilization has not changed significantly.
 - There was a 126% increase in the number of general LifeNet calls from the year pre-September 11th (October 2000 to September 2001) to the year post-September 11th (October 2001 to September 2002).
 - There was only a 4% increase in the number of Asian LifeNet calls over the same periods.
- A greater percentage of crisis and emergency calls⁹⁵ are made to Asian LifeNet as compared to LifeNet's general and Spanish language (*AYUDESE*) phone numbers.
- Asian LifeNet reports that hotline calls tend to follow its mental health educational broadcasts on Chinese radio.

⁹³ In addition, to help parents understand their children's mental health needs, CORE is conducting a public education campaign via Chinese language newspapers and radio.

⁹⁴ January - June 2001 was compared to January - June 2002.

⁹⁵ One out of every 67 calls to Asian LifeNet are for "crisis emergency," as compared to one out of every 125 of such calls to general LifeNet.

D. Summary of Service Utilization

Mental health services have been greatly under-utilized both by family members of Asian victims and Chinatown children, elders, and dislocated workers. Between September 12, 2001 and February 14, 2003, of the 315 family members of Asian victims who accessed American Red Cross services, only eight utilized its mental health benefits (Of these, three were outside of the U.S.). Additionally, while general LifeNet service utilization has greatly increased after September 11th, the level of Asian LifeNet service utilization has not changed. And, referrals for mental health services were only made to approximately 4% of the population that was assessed⁹⁶ through Project Liberty.

Professional mental health services were perceived to be unhelpful, inappropriate, or irrelevant by study participants. Study participants considered obtaining concrete assistance a much higher priority than getting help for mental health issues. When study participants sought emotional support, they received it most often through their own social networks and other support systems, i.e., family, friends, peers, and religion/spirituality. Study participants preferred culturally embedded means of alleviating physical symptoms of stress, such as the use of herbal medicines and acupuncture over Western therapies.

For the few victims' family members who sought professional mental health services, services were largely not provided by professionals of the same cultural and linguistic background. Those who saw professionals of a different background tended to have a more difficult time communicating with the provider and did not perceive mental health services to be as useful. Translators were not available in most cases when the professional was of a different background.

Mental health services were utilized more in acute stages of mental illness or perceived to be useful only in these stages. A greater percentage of crisis and emergency calls are made to Asian LifeNet as compared to the general LifeNet and *AYUDESE* (Spanish) LifeNet telephone numbers.

Study participants felt that professional mental health services are a last resort, or only to be used for severe cases of mental distress. According to interviews with mental health and social service administrators, the Fujianese population, many of whom are undocumented and uninsured, tend to delay treatment even more than other Chinese groups - until their issues have progressed into much more severe and difficult-to-treat conditions.

Mental health service utilization was associated with services that were:

- Located in non-clinical settings⁹⁷;
- Provided by professionals who share the clients' cultural and linguistic background;
- Recommended by a trusted individual (e.g., family member, friend, social service provider);
- Publicized over the radio, in the case of Chinatown.

⁹⁶ Only 101 referrals to mental health services through Project Liberty/Hamilton-Madison House were made to a total of 2,404 individuals from the four study groups (victims' families and Chinatown children, elderly, and dislocated workers).

⁹⁷ I.e., In the home, places of worship, in organizations where they are receiving other supportive services, schools, job-training centers, senior centers.

E. Summary of Findings: Expressed Unmet Needs and Service Gaps

Despite the assessments that all victims' family members were depressed or mildly depressed, and that most focus group participants in Chinatown were at risk for developing negative mental health outcomes, mental health service utilization among these groups was extremely low. The interviews with victims' family members and focus group participants revealed that very few participants received help from mental health service providers or tried to learn about available mental health services. In general, these groups regarded counseling as unhelpful. However, the research findings highlight that the existing coping methods have not adequately addressed emotional difficulties associated with September 11th, and that significant barriers prevent adequate access and utilization of mental health support sources.

Questions pertaining to the unmet needs and gaps in mental health services were asked of study participants, health, mental health and social service providers, and relief agency staff through interviews, focus groups, and surveys. This section presents the key findings in these areas.

1. Unmet Needs

Mental health awareness needs to be instilled among Asian families of victims and Chinatown's children, dislocated workers, and elderly.

- Before professional help can be openly and effectively utilized by those who need it, negative social attitudes and general misinformation about mental health and counseling must first be rectified.
- A public health campaign needs to be formulated and executed that provides victims' families and Chinatown residents with an accurate understanding of mental health issues, including the consequences to normal life functioning of prolonging or not addressing emotional problems.

Victims' Families

Long-term professional emotional support for Asian families of victims is greatly needed to help them cope with their continued sense of loss as well as the stress associated with changes in the family.

- Informal supports alone were largely insufficient to relieve the depression and stress levels of interview participants, as assessed by the interviewers, who are licensed mental health professionals.
- Research from the Oklahoma City bombing shows that the need for mental health assistance following a trauma can persist for years. In that case, mental health services were still being utilized three years later⁹⁸.
- Many victims' families emphasized a preference for support groups as a less stigmatized opportunity to share with others who have experienced similar losses. Mental health professionals who are trained to address issues of bereavement and loss should lead such groups.
- Victims' family members expressed their appreciation for social and recreational activities, which not only help those in emotional distress and isolation but also free up time for other family members who are obligated to care for them.

⁹⁸ *Project Heartland: A Report on Project Heartland, Oklahoma's Crisis Counseling Services for Those Affected by the Murrah Federal Building Bombing on April 19, 1995.* Oklahoma Department of Mental Health and Substance Abuse Services, May 31, 1998.

Victims' families cited a need for easily accessible information on bilingual resources and services.

- Victims' families had a low level of initiating help-seeking for all kinds of services. In light of this, it is essential that assistance be as accessible as possible.
- The issue of service availability precedes even that of accessibility. Currently, there are few mental health educational resources in languages other than Chinese.
- Victims' families specified that a central resource center would be helpful. Mental health professionals added that such centers provide a much-needed anonymous place to access services.

Victims' families emphasized the importance of making available various forms of emotional support to individuals close to them, such as friends and neighbors, who did not know how to interact with them under the circumstances.

- Victims' families have been isolated from needed help because others did not know how to interact with them.
- Supportive and educational groups and workshops were specified as forms of assistance that would be helpful.

Chinatown

For children in Chinatown, sustained interventions are necessary to give children opportunities to interact with adults trained to help them address feelings, thoughts, and concerns associated with the emotional consequences of September 11th.

- Some consequences of failing to treat childhood mental health problems observed among Chinatown children are general decreases in functioning, including school failure, suicidal ideation or talk, and acting out behavior.
- Many of the mental health consequences that would be seen are not necessarily ones that would bring children to an outpatient mental health treatment center.
- Children are less equipped to express their emotions and more dependent on adults to help them address their needs.
- Long-term care is necessary because trauma can persist for years beyond the event.

Parents, school personnel, after-school and child care providers need education to deal with mental health consequences in their children.

- Adults need to cultivate the ability to detect mental health issues in children through culturally relevant training.
- Adults need to learn culturally and developmentally appropriate and effective ways to enable themselves and their children to cope with children's mental health consequences.

Families in Chinatown need help to deal with anxiety and stress symptoms due to unemployment, persistent post-traumatic stress symptoms, and increased familial tensions and conflict.

- Mental health issues affect the ability to obtain and sustain employment, which can lead to a destructive spiral of prolonged negative impacts on mental health and employment status.
- More efforts to link services providing mental health help and those providing concrete assistance are needed.
- Focus groups with Chinatown children revealed that mental health issues impact all family members. Children have observed tensions in the family as a result of lost employment and have reported that conflicts between parents can be very stressful.

Geriatric mental health services are needed to help Chinatown elderly address their post-traumatic stress symptoms and their continued sense of hopelessness and helplessness.

- In Chinatown outpatient mental health facilities, only 122 to 134 slots are available to address elderly issues at any given time.
- Homebound or socially isolated elderly are particularly difficult to access and treat.

2. Service Gaps

There is a shortage of culturally relevant forms of mental health support.

- Services outside the traditional clinical setting are needed to increase access by groups that historically underutilize these services. Examples of such settings are churches, temples, and mosques, the home, job-training centers, senior centers, and schools.
- Western therapeutic approaches are not as effective for Asian immigrant families, especially those of lower socioeconomic status.

Victims of Indian descent were the largest ethnic group of Asian victims, and nearly half of all Asian victims of World Trade Center were South Asian. However, most mental health programs and services, including those designed to serve Asians, lack trained professionals with bilingual capabilities and cultural competence to work with South Asian family members.

- There are no South Asian staff members at Asian LifeNet and the American Red Cross and few at Project Liberty.
- With the exception of SACSS, most organizations that are providing supportive services to South Asian victims' families are not actively focusing on or making referrals to mental health services.
- Mental health outreach and public education activities (e.g., radio programs, community forums) have largely not been conducted in the South Asian community.
- There are few mental health education materials in South Asian languages. At the time of this report, there were no materials produced by FEMA/Project Liberty, MHA/Asian LifeNet, or the American Red Cross in any South Asian languages.

Little targeted outreach to victims' families has been conducted by such major September 11th-related mental health programs, as Project Liberty and Asian LifeNet, as well as other community-based mental health providers in New York City.

More Asian victims resided in New Jersey than in New York City. Their family members have even less access to culturally-appropriate mental health care than New York City residents, due to the lack of such service programs outside of the city.

- According to the New Jersey Institute for Family Services, no targeted efforts have been made to reach out to Asian victims' families, and few of these individuals have been served.

Few organizations that provide supportive services to family members of victims are staffed by trained mental health professionals.

- Reportedly, only two organizations (FAHSI, SACSS) that provide case management assistance to Asian victims' families employ trained mental health professionals; these groups serve Filipino and South Asian communities. These professional mental health positions are funded only on a temporary basis.
- Organizations serving other Asian groups with large numbers of victims, such as the Chinese, Japanese, and Korean, do not have such professionals on staff.

Mental health services need to be linked and coordinated with culturally relevant non-clinical support programs in which family members of victims participate.

- Family members of victims have been more receptive to participating in support groups and recreational activities with other families that have shared the same experience of loss than to seeking therapy.
- Group facilitators and activity leaders are not mental health professionals and generally do not have a mental health orientation in leading these groups.
- Mental health service providers have not targeted their attention towards victims' families and these other forms of support.

Most front-line, direct service staff members of Project Liberty and September 11th case-management programs lack mental health backgrounds. Mental health training, if any is received, is generally superficial and inadequate. In addition, some programs don't have enough Asian-language staff members.

- Mental health training for The September 11th Fund Ongoing Recovery Program:
 - is not a requirement and
 - does not cover issues of cultural competence.
- Consequently, the issue of mental health, much less culturally competent mental health, is generally not being adequately addressed in case management.
- Pro-active case management to facilitate mental health linkages (e.g., initiating calls to service providers on behalf of the client when necessary and following-up after referrals to services are made) is rare.
- Large caseloads may restrict the ability of case managers to assist those who do not voice the need for assistance.
- In the case of the American Red Cross, there are no Asian language speaking staff at the central call center, the first point of contact for many who would eventually be assigned a case manager. The American Red Cross has only two Asian case managers in the Family Support Services Center, with Mandarin, Korean, and Japanese language abilities, collectively.

Few family members of victims as well as affected individuals in Chinatown have received ongoing mental health care. Post September 11th mental health assistance has focused on initial assessment and/or crisis intervention, with few referrals to longer-term services.

- Research from the Oklahoma City bombing demonstrates that the effects of trauma can persist for years, especially if untreated or unaddressed.
- The current⁹⁹ funding for mental health services in Chinatown area schools will terminate in December 2003. Funding needs to be extended beyond this timeframe.
- The existing mental health programs are limited in their ability to serve clients because they are 1) over-capacity, and 2) the span of treatment is often short-term.
- According to interviews with mental health service providers in September 11th supportive services agencies, it is difficult to refer clients to mental health services due to capacity issues.
- The existing community mental health providers mostly treat individuals with more persistent or serious forms of mental illness. As evidenced in the focus groups and provider interviews, many Chinatown populations will not seek mental health services until their issues become very serious.
- Help is difficult to get for many, especially those with milder issues but who nonetheless need professional mental health support.

⁹⁹ As of March 2003.

VI. Chapter 4: Public Policy Recommendations

Goal 1: Develop more culturally competent mental health services and other forms of support.

- 1.1** Linkages and collaboration should be established or strengthened between mental health services and other programs or venues where individuals and families go for concrete help or emotional support. These venues may include schools, job training programs, health clinics, senior centers, formal and informal support groups, as well as places of worship.
- 1.2** These and other mental health services should incorporate practices based on alternatives to existing Western clinical models, which Asian Americans are culturally less inclined to accept.
- 1.3** With FEMA's Project Liberty funding slated to expire in December 2003, continued funding commitments from federal and state governments as well as private foundations are needed to address the long-term mental health needs of affected populations, especially victims' families and Chinatown populations, with considerations for culturally competent mental health services offered in non-traditional or community settings. Therapeutic social and recreational activities that do not carry the cultural stigma of traditional mental health interventions should also be funded.

Goal 2: Create greater awareness of mental health issues and knowledge of bilingual services and resources through the expansion of outreach and community education.

- 2.1** Special outreach efforts should be extended to families of Asian victims, particularly South Asian families as well as families living in New Jersey. Extended family and significant others should also be included, which is important because, while Americans regard the primary unit as the individual, for Asian Americans, the primary unit is the family.
- 2.2** Information about available, culturally competent mental health services provided in various Asian languages, especially South Asian languages, should be compiled to supplement existing resources on assistance for affected individuals, such as the *September 11th Assistance Guide*, a 9/11 USG-sponsored online directory of information and services.
- 2.3** Information about September 11th-related assistance, including that which is Internet-based, should be made available in relevant Asian languages to enable

limited English proficient individuals to access information independently. In particular, individuals who need mental health help may be deterred, out of shame or embarrassment, from seeking such services if they must rely on others to gather this information.

- 2.4 Special efforts should be made to inform the Chinatown public, including the opinion leaders of Chinatown, such as family associations and religious figures, about the mental health impact of September 11th.
- 2.5 More community education materials should be developed by culturally-competent mental health professionals with relevant field expertise in areas such as bereavement, child psychology or geriatric mental health. These materials should be translated into relevant Asian languages.
- 2.6 Community education should be provided in more varied forms, including Asian-language radio and television programming.
- 2.7 Educational material development and dissemination efforts should target families and caregivers of those with mental health issues, to help service recipients relate better to these individuals, as well as develop and strengthen their own coping methods.
- 2.8 Private and public health insurance programs should be required to promote mental health benefits using bilingual informational materials and media programs with culturally sensitive content and benefit descriptions.

Goal 3: Increase the availability and accessibility of mental health programs that address the long-term needs of victims' families.

- 3.1 Asian Americans, if they do seek treatment, typically enter the mental health system at a later stage of illness compared to the general population. The September 11th Fund and the American Red Cross should modify the current reimbursement structure to allow their mental health benefit to be accessed for up to five years from the time treatment is initiated by the individual, since victims' families have not been accessing this benefit since its inception. The current program span is three to five years from August 2002.
- 3.2 Programs should be encouraged that help victims' families ease stress associated with changes in the family, such as increased financial obligations, family responsibilities or related culturally-based conflicts. An example of a culturally - based conflict occurred in one family when the parents of a deceased individual blamed his wife, their daughter-in-law, for their son's death, believing that she brought misfortune upon the family. Another example occurred in the case of a financial dispute between another victim's spouse and the parents of that victim, originating from the parents' ineligibility for compensation benefits. In this case, the benefit program did not consider the parents "next of kin."
- 3.3 Programs for victims' families should extend emotional support and guidance to individuals who are close to these families, including friends and caregivers.
- 3.4 The American Red Cross and The September 11th Fund should supplement insurance coverage of their mental health initiative with direct funding to community programs that effectively bridge mental health care gaps for victims' families. Professional mental health services should be linked to more natural settings for victims' families, such as concrete service settings, places of worship, or the home.

- 3.5 Mainstream coordinating organizations, such as the Mental Health Association, the American Red Cross, and 9/11 United Services Group, should work more closely with previously established community mental health programs to serve victims' families more effectively.
- 3.6 Culturally and linguistically competent Asian American mental health professionals in the New York metropolitan area should be identified and matched with programs serving victims' families through volunteer opportunities, consulting assignments or collaborative institutional arrangements.
- 3.7 Mental health services and case management initiatives should be developed to serve New Jersey-based families of victims in their home communities. Funding should be allocated toward the development of a central resource center to provide an anonymous place for victims' families in New Jersey to access services.

Goal 4: Strengthen the ability of mental health services to assist children, the elderly and families in Chinatown.

- 4.1 A wide range of traditional and non-traditional programs should be developed that help children cope with the tragedy. Funders should recognize and contract with programs that develop coping skills, emphasize strengthening and creating relationships, and foster self-esteem and a sense of safety.
- 4.2 Parents and professionals, such as school personnel, after-school and child-care providers, and healthcare workers, especially those without knowledge of the psychological make-up and behavior predispositions of Asian Americans, should be trained to identify mental health issues in children and to enact effective coping strategies for the children and themselves.
- 4.3 Sustained programs are needed to help senior citizens deal with post-traumatic stress symptoms, as well as their sense of loss, grief, hopelessness and helplessness stemming from September 11th. Special efforts to reach out to homebound elderly are necessary.
- 4.4 Because mental health issues frequently manifest themselves as physical health symptoms in Asian Americans, and because primary care is more accessible for this group, primary care for affected populations should include mental health screening and referrals.
- 4.5 Efforts should be made to help economically disadvantaged families cope with emotional consequences of unemployment and underemployment, as well as associated family tension and conflict.
- 4.6 The September 11th Fund should extend coverage beyond the current one-year time limit from the time of enrollment for its Ongoing Recovery Program, which provides public health insurance eligibility screenings and free health insurance to unemployed Chinatown workers.
- 4.7 Mental health service providers should collaborate more closely with programs serving children, the elderly and working adults, to facilitate more effective intervention for these populations.
- 4.8 Free mental health services should be expanded to include extended family and significant others of all victims and affected individuals.

Goal 5: Increase mental health training and bilingual capabilities of front-line staff for programs serving victims' families and Chinatown populations.

- 5.1** FEMA/Project Liberty and September 11th case management programs should require adequate, culturally-competent mental health training and supervision for all front-line, direct service staff members.
- 5.2** Public and private relief organizations should ensure that case managers follow-up on mental health referrals.
- 5.3** FEMA/Project Liberty, the American Red Cross, The September 11th Fund, and Mental Health Association should collaborate with Asian American mental health experts to develop mental health training courses and materials for those who work with September 11th victims' families, as well as Chinatown children and youth, elderly residents, and unemployed workers. Training opportunities should be offered to all who work with these populations in the New York metropolitan area.
- 5.4** The American Red Cross should address the lack of language ability in Bengali, Cantonese, and Hindi for its Family Supportive Services case management program and its call center, which are its two main points of entry for services and benefits.
- 5.5** The Mental Health Association/Asian LifeNet should provide its hotline services in various Asian languages besides Chinese and Korean, especially Hindi, Bengali, Urdu, and Tagalog.

Goal 6: Expand community and professional knowledge and practice base regarding Asian American mental health issues and programs.

- 6.1** Additional research is needed to assess longitudinal mental health effects on families of Asian World Trade Center victims as a group, as well as for further research on mental health issues of other vulnerable groups that have received scant attention, such as the undocumented population in Chinatown.
- 6.2** Foundations and government entities should provide funding to support further study and development of culturally-competent mental health practices to serve Asian Americans affected by September 11th experiences.

Goal 7: Develop a coordinated Asian American community mental health planning framework for a post-September 11th era.

- 7.1** Mental health planning for future disasters should include considerations of the cultural competence and linguistic appropriateness of services for Asian Americans in the New York metropolitan area.
- 7.2** Coordinated planning efforts should be supported among community mental health service providers to increase mental health service utilization through effective community outreach and education; improved access to available services; strengthened service infrastructure; better coordination in service referrals; greater cultural competence in service provision; development, implementation, and evaluation of best practices; and greater ability to inform mental health policy affecting Asian Americans.

- 7.3** The New York State Office of Mental Health should demonstrate an ongoing commitment to ensuring that cultural competence and other quality-of-care standards are met in its funded and certified programs with respect to services for Asian Americans. Such institutional commitment should be clearly operationalized by, at minimum, assigning responsibility for this issue to senior level staff and institutionalizing processes for participation of Asian American mental health professionals in OMH program planning and policy development.

Appendix A: Methodological Approaches

A. Qualitative Approaches

1. Victims' Families

A qualitative approach was used to examine the specific experiences of Asian American victims' families in relation to the WTC attack. Mahrer's¹⁰⁰ discovery-oriented qualitative research approach was used to analyze the data and to help identify themes across interviews. There are two approaches to this method: 1) to provide a closer, discovery-oriented look at the phenomenon under study and 2) to discover the relationships between conditions, observations and consequences within a psychotherapeutic situation. Although typically used within a psychotherapeutic context, the first approach was suitable for the study due to its primary premise of learning about psychological aspects of the family members' experience. Moreover, the researchers were interested in identifying what one might not already know or predict, according to this approach. Furthermore, according to Mahrer, the key features of this approach are that: 1) it allows for rigorous scientific theory building, 2) generates advances in clinical practices, 3) opens up new methods of conceptualization, and 4) allows for integrating theory, research and practice.

There are several steps involved in this method:

- Selecting an area of study. The experience of Asian American family members of victims of the September 11th tragedy.
- Development of an instrument and establishing categories that allow a closer look at the phenomenon under study. The interview questionnaire/protocol focused on particular themes/categories to assess the family members' experiences. In particular, the researchers identified 6 categories for study (e.g., feelings, coping methods etc).
- Obtain instances of the target of investigation by audiotaping the interviews conducted with each participant.
- Obtain or gather data by having research assistants examine each excerpt one by one, identifying and refining categories.
- Making discovery-oriented sense of the data through scanning the data. This occurs through organizing and reorganizing the data into a categorical system of general themes and domains. It was believed that this method of research would provide for an in-depth, subjective analysis of the study participants' experiences.

Recruitment

49 families were contacted, and 28 family members agreed to be interviewed. Of these 28, 22 people were interviewed.

¹⁰⁰ Mahrer, 1988.

Recruitment took approximately six weeks for South Asian families and three weeks for other Asian families from the time of the project's initiation.

Participants were recruited through outreach and contact with:

- Three Consulates¹⁰¹;
- National and community-based social service organizations¹⁰²;
- Mainstream and Asian-language press contacts¹⁰³;
- Churches, temples and mosques;
- Other personal and victim family contacts;
- Community mental health clinics and related organizations;
- Any volunteer Asian victim's family member (18 years of age or older) who was connected at the time of the recruitment period with organizations registered on a contact list of the Asian American Federation of New York (AAFNY).

Procedure

Interviews were conducted approximately nine months after September 11, 2001. Once participants were identified, telephone calls were made to each participant by the primary researcher or a researcher connected to the project if a language other than English was needed to communicate. During the conversation:

- They were informed that these interviews would be audiotaped for later transcription, and that their anonymity would be preserved.
- Participants were told that they were free to withdraw from participating at any time.
- After an initial contact, during which the study was described, potential participants each received a questionnaire packet. The questionnaire packet included an explanatory cover letter, a demographic form, and the interview protocol. All packets were available in English and in the native languages of the potential participants.
- Once participants agreed to be interviewed, interviews were conducted either on the same day or very close to the consent date, based on their availability following the phone contact.
- Fifteen out of 22 interviews were conducted in English, five in Korean, one in Hindi, and one in Mandarin.
- At the completion of the interview, participants received a gift of \$50 and a prepaid phone card.

Measures

Demographic Questionnaire

This form was used to elicit descriptive data by obtaining information related to gender, age, birthplace, ethnic background, age at immigration, marital status at immigration, visa status at immigration, current visa status, generational status, education level, occupation, religious affiliation, socioeconomic status, first language, most proficient language, previous experience with counseling, and relationship to victim.

Interview Protocol

The researchers developed an instrument that allows for a deeper understanding of the experiences of the family members and their personal reactions to the WTC attacks. In developing the instrument, the research team discussed relevant categories to be targeted for investigation based on the purpose of study and clinical and research

¹⁰¹ Consulate General of India, New York; Consulate General of the People's Republic of Bangladesh, New York; and General Consulate of Pakistan in New York.

¹⁰² United Way of New Jersey of Middlesex Co., New York Asian Womens' Center, South Asian Council for Social Services, D.R.U.M. (Desis Rising Up and Moving), the Urban Justice Center, Filipino American Human Services, Chinese Christian Herald Crusades, Tzu-Chi Buddhist Foundation, Chinese-American Planning Council.

¹⁰³ South Asian press: India Abroad, Thikana, News India Times, New York Times, and the South Asian Journalist Association based in Columbia University; Chinese press: World Journal, China Press, Mingpao News, Singtao News, 1480 Broadcast Radio, and Sino TV.

experience with the target group. Thus, the interview questionnaire/protocol focused on particular themes/categories to be assessed in understanding their experience. In particular, six identified areas are:

- Reactions related to the event;
- Feelings related to the event;
- Ways of coping, supports sought;
- Gaps in utilized services;
- Future programs needed;
- Other experiences pertinent to Asian Americans (e.g., circumstances of immigration, family support networks, role of religious affiliation, etc.).

Transcripts

Members of the research team transcribed the interviews verbatim. These transcriptions were then double-checked by a different member of the research team, who listened to the original audiocassette. To ensure semantic equivalence¹⁰⁴, interviews that were conducted in a language other than English were translated into English by a member of the research team and then back-translated to the native language by a different research team member.

Data Analysis

The analyses of the transcribed interviews consisted of moving from specific utterances to generating domains and categories based on group rather than individual thought and action¹⁰⁵. Two judges/expert raters went through each excerpt individually, examining specific utterances. This involved identifying data that may be different, unexpected, exceptional, surprising, challenging, or disconcerting¹⁰⁶. This procedure was followed by identifying provisional categories, refining the categories, and reorganizing the data on the basis of the developing category system. This occurred through scanning the data, being open to leads, exploring various patterns, attending to repeated instances, and organizing and reorganizing the data to develop general patterns and themes that evolved within the data.

2. Chinatown's Vulnerable Populations

The focus groups adhered to an interview guide for each specific population with a three-fold design:

- To learn about the experiences and perspectives of the participants in relation to the September 11th attacks and their coping and help-seeking behavior.
- To obtain a consensus regarding service recommendations that will benefit the population of the participants.
- To allow for the generation of more in-depth and individualized information, open-ended and inductive approaches were used in the group sessions as much as possible.

Recruitment

A total of 18 focus groups were held in the Chinatown community: five groups each for the elderly and dislocated workers and eight groups for the children. A total of 145 participants attended the groups. The average size of the adults' groups was ten participants, and the average size of the children's groups was seven participants.

- Several major social service organizations in the Chinatown community were contacted via letters, phone contacts, and presentations in staff meetings to solicit their support in recruiting participants.
- Announcements for the study and preliminary interview guides were sent to organizations that expressed interest in hosting focus groups for their constituents

¹⁰⁴ Brislin, 1980.

¹⁰⁵ Inman, Constantine, & Ladany, 1999.

¹⁰⁶ Mahrer, 1988.

who met the eligibility criteria.

- Contacts were made with the staff liaisons of the various host agencies to finalize recruitment and focus group procedures.
- Potential participants who met the eligibility criteria of the study were identified by each host agency's staff liaison. A letter about the purpose and content of the study and protection provisions for the rights of participants, a consent form, and a brief demographic questionnaire were given to potential participants. Individuals who returned a completed questionnaire and signed consent form were randomly assigned to the various scheduled groups. In the case of children, this procedure was done via their parents or guardians.

Procedure

- Each focus group was conducted on the site of the host agency.
- Focus groups for the elderly and dislocated workers lasted approximately an hour each. Focus groups for the children lasted between 30 to 45 minutes, depending on the size of the group.
- The Principal Investigator served as the moderator for all the focus groups.
- The focus groups for the elderly and dislocated workers were conducted in Chinese (i.e., Cantonese and Mandarin dialects). The children's focus groups were conducted in English.
- All the focus group sessions were audiotaped with the permission of the participants. The tapes were transcribed verbatim from Chinese to English.
- The demographic questionnaires for each population were compiled separately.
- Field notes were taken by the Principal Investigator at the conclusion of each focus group in regard to the group process, verbal and non-verbal behavior of the participants, and emerging themes of the discussions.
- Debriefing was offered to all participants at the end of the group session. Individual time was spent with those who appeared to be emotionally affected during the sessions.
- Elderly and dislocated workers were encouraged to discuss ideas pertaining to service gaps and recommendations.
- Children were asked at the end of the group sessions to write down "wishes" for themselves and their families as another alternative to explore their feelings.
- Participants of the elderly and children's focus groups were each offered a \$10.00 gift certificate. Participants of the dislocated workers' group were each offered a \$20.00 stipend.

The Focus Group Process

Structure

Group rules regarding speaking protocol, respecting differences of opinion, and honoring confidentiality of information shared in the group session were explained to the participants. Warm-up dialogues and introductions were held with the participants in the beginning of the session. Each participant was invited to take turns to answer open-ended questions posed by the group moderator, and some participants were asked to elaborate on issues that were deemed significant by the group moderator. Debriefing was offered to all the participants at the conclusion of the group session.

Communication Patterns

By population:

- The elderly talked in great detail and with strong emotion about their experiences of September 11th.
- The dislocated workers responded to sensitive questions about their unemployment with little probing by the group moderator. Some of them expressed anger and frustration at their predicament and the inadequacy of services and benefits.
- Children tended to be less articulate in describing events and needed probing and

reflection time to discuss their feelings. Some of them seemed to be unsure about the chronology of events. Others were tentative about their opinions and often changed their minds upon hearing other children's responses.

By gender:

- Male adult participants expressed their sadness in a more quiet and subdued manner (i.e., measured words, silence, lowered heads) while others were more vocal in expressing anger and strong opinions.
- Female adult participants expressed their sadness and anxiety more readily through verbal articulation and facial demeanor.
- Male children tended to express their sadness and anxiety in disguises of aggressive fantasies (i.e., punishing and destroying the "bad guy", etc.).
- Female children tended to be more direct in acknowledging their sad and vulnerable feelings.

Group Dynamics

There was a high level of comfort among the participants in their interactions with each other, since most of them knew each other from their affiliations with the host agencies. For all the participants, this was the first time they discussed their personal experiences and feelings regarding September 11th.

Role of Group Moderator:

The group moderator made special efforts to create a safe and therapeutic environment for the participants. Supportive statements were made to validate participants' feelings and normalize their reactions. Allowances were made for silences as well as additional time for rehashing painful memories. Efforts were made to engage those who exhibited resistant behavior by eliciting support from other participants.

Data Analysis

The organization and analysis of the data were largely performed by identifying themes in the transcripts of the focus group discussions. Ely¹⁰⁷ define a theme as "a statement of meaning that 1) runs through all or most of the pertinent data, or 2) one in the minority that carries heavy emotional or factual impact."

During the initial reviews of transcripts, labels were used to conceptualize and code "meaning units" that denote phenomena and issues relevant to the study. They were then grouped into tentative categories with titles. After codes and categories were reviewed and finalized, verbatim narratives by the participants were selected from the transcripts to provide a clearer illustration of the content. The investigator's field notes and demographic data provided by the surveys were used to supplement the final analysis of the findings.

B. Quantitative Approaches

1. Chinatown Population and Transportation Analysis

This report uses Census 2000 sample data to provide a detailed demographic analysis of Chinatown's residential population, with the larger aim of presenting a contextual overview of this community prior to September 11th. Specifically, the overview examines contextual factors using SF2 and SF3 Census 2000 data, which allow the definition of Chinatown's boundaries using block groups or Census tracts.

The Chinatown Area Mental Health Service Providers Map (See Appendix D, Figure 9), was created to analyze the proximity of mental health services to the Asian population

¹⁰⁷ Ely, *et al.*, 1991.

in the Chinatown area. The Asian population data is block-level Census 2000 Asian Alone or in Combination data derived from the PL-Redistricting Summary File. The mental health service providers were geocoded (mapped relative to their address), according to the type of mental health service provided by the facility onto the street map. The mental health service providers that provided both outpatient treatment and day treatment will show both corresponding symbols on the map at their address. The Chinatown Area Mental Health Service Providers & Public Transportation Map (See Appendix D, Figure 10), was created using the same mental health service providers information and process as mentioned above. Additionally, we obtained the subway station shape files from a contact within the NYC Metropolitan Transportation Authority ("MTA"). The train routes for each station were derived using public MTA subway maps, as of December 2002. Federation staff created the bus routes using data derived from MTA bus route maps, as of December 2002.

2. **Project Liberty**

In Fall 2002, the Federation established a relationship with Hamilton-Madison House to share one year's worth of data (i.e., October 2001-September 30, 2002) from their organization's Project Liberty program. Permission was granted from New York State Project Liberty to use this data. Hamilton-Madison House supplied a database technician who developed a web-based database and was responsible for running data queries and producing web-based graphs and tables with the query results. The Federation employed ten assistants to perform the data entry of approximately 14,000 (see "Data Sources" table, below) one-page intake sheets. The entered data were spot-checked for accuracy and cleaned where necessary. The research team devised a series of queries for the database under the guidance of project consultants and members of the advisory team.

Data Analysis

a. Victims' Families

The Project Liberty intake form includes a section that records categories of September 11th-related situations or circumstances that place individuals at particular risk for negative mental health outcomes, including the "Injured," "Fire Department," and "Police Department." One of these risk categories is "Family of Missing/Deceased."

The data for this category were organized by two groups:

- i. General Population;
- ii. Asian and Pacific Islander Population (API).

The numbers of responses pertaining to reactions and referrals were totaled, and "Unknown" responses were excluded. The totals for reactions and referrals were compared, and differences between groups of two percentage points or higher were reported.

b. Chinatown's Vulnerable Populations

Another category of risk on the Project Liberty intake form was "Displaced Employed and Unemployed." This category was examined in conjunction with the age categories, also recorded on the form, of Childhood (6-11) and Older Adult (55 and over). There was no category of elderly, i.e., age 65 and over, on the intake form.

The data for these three populations were organized by the following groups:

- i. General Population: the entire universe of Hamilton-Madison House assessments, which covers all of New York City.
- ii. Asian Population: those within the universe of assessments who identified as "Asian & Pacific Islander," in the ethnicity category.

- iii. Chinatown population: those within the API population who were assessed within the four Chinatown ZIP codes (10002, 10012, 10013, and 10038). The assessment form does not record residential information nor specific ethnicity. According to an earlier study¹⁰⁸ by the Federation, ninety-five percent of the Asian population in Chinatown is of Chinese origin. On this basis, the research team focused on the API population within these four ZIP codes as the best approximation for the Chinatown community.

The numbers of responses pertaining to reactions and referrals were totaled, and the “Unknown” responses were excluded. The totals for reactions and referrals were compared, and differences between groups of two percentage points or higher were reported.

3. Asian LifeNet

The Federation research team worked with Asian LifeNet staff to identify the areas within the organization’s database that capture the service utilization patterns that were of interest for the purposes of this study. Data were gathered on 1) presenting problems, 2) services discussed during the call, 3) the types of referrals made, and 4) overall number of calls to the hotline. These data reflected service trends across various periods in the year after September 11th as well as during the corresponding time periods in the year prior to September 11th. The latter was included for the purposes of a pre-post comparison and to account for seasonal variation.

4. WTC Asian victims’ profiles

The Federation compiled a list of all known deceased WTC victims of Asian descent using reports from the New York City Department of Health and victims’ profiles from the following websites:

- New York Times
- CNN
- MSNBC
- www.september11victims.com

Based on these profiles, Federation staff developed the most comprehensive listing of known deceased Asian victims, totaling 184 individuals. This list includes demographics and detailed background information such as ethnicity, occupation, place of employment, age, gender, marital and family status, residence, ZIP code¹⁰⁹, hobbies/interests, and surviving relatives.

5. American Red Cross

The Federation worked with a database technician and other staff at the American Red Cross to cross-reference the names of the deceased Asian victims with their own database of all family members that had utilized services, received benefits, or otherwise made contact with American Red Cross.

C. Methodological Considerations

The research team conducted in-depth interviews with survivors of 22 Asian victims, 11 of whom were of South Asian descent. This reflects the overall demographic pattern showing that half of the Asian victims’ were South Asian. Using a variety of institutional, community and personal outreach and recruitment strategies, the research team interviewed study participants on a voluntary basis. Though the findings may not be generalizable to the wider

¹⁰⁸ Asian American Federation of New York, November 2002.

¹⁰⁹ ZIP codes were identified using information on city of residence and the following websites: www.Quikthinking.com, www.newyork.areaconnect.com, www.newyorkjewelry.com/html/Queensmap.htm, www.555us.com/555NY/555ny_zipcodes.htm, and www.zipinfo.com.

victims' families population, this in-depth analysis reveals critical insights about the experiences of these families in dealing with their loss associated with September 11th.

The focus group sessions conducted in Chinatown focus on three vulnerable populations: elderly, children and dislocated workers. The research team targeted participants in daycare centers, senior centers and job training programs in the community. It did not focus on the experience of residents that did not use social services. Again, due to this targeted approach on participants who are part of the social services network and the voluntary nature of focus group participants, the generalizability of these findings is naturally limited. Nonetheless, the research, which is the first-ever-systematic attempt to assess the mental health impact on a neighborhood close to Ground Zero, documents the untold and important experiences of Chinatown residents and workers in coping with the tragedy.

The Project Liberty information on victims' families and Chinatown represents a collection of quantitative data by the largest September 11th community-based mental health program serving Asian Americans. As such, the inclusion of this program data on mental health symptoms and referrals was imperative. However, caution should be employed in interpreting these findings, as the intake form, the data from which the study's analysis was based, was designed to be a Project Liberty program implementation tool rather than to serve as a research instrument. The quantitative data provide a supplementary basis for supporting or refuting the qualitative findings.

Overall, this study fills an important gap in understanding the mental health consequences of September 11th on Asian victims' families and on Chinatown. The findings in this report provide an important knowledge base for mental health policy making and practice as well as an important baseline for future longitudinal research on victims' families and Chinatown community residents.

D. Data Sources

SOURCES OF DATA	SIZE (N =)	TIME PERIOD COVERED											
		JUN. '02	JUL. '02	AUG. '02	SEP. '02	OCT. '02	NOV. '02	DEC. '02	JAN. '03	FEB. '03	MAR. '03	APR. '03	MAY '03
Chapter One: The Mental Health Impact of September 11th on Asian Victims' Families													
List of Federation-compiled Asian victims' demographics (from <i>The New York Times</i> , <i>CNN</i> , <i>MSNBC</i> , and www.september11victims.com)	184	X	X										
Study participants demographic questionnaire	22	X	X	X									
Interviews with victims' families	22	X	X	X									
Project Liberty *	24	X	X	X	X								
Chapter Two: The Mental Health Impact of September 11th on Chinatown													
Census 2000													
Focus groups with Chinatown populations	145	X	X										
Demographic questionnaires of study participants	145	X	X										
Surveys of Chinatown area mental health service providers	11		X	X	X	X	X						
Survey of social service providers	38	X	X	X									
Interviews and focus groups with mental health service providers and administrators	25	X	X	X									
Project Liberty *	2,380	X	X	X	X								
Chapter Three: September 11th-Related Mental Health Initiatives, Service Utilization, Unmet Needs, and Service Gaps													
American Red Cross**	315	X	X	X	X	X	X	X	X	X			
September 11th Fund		X	X	X	X	X	X	X	X	X			
Mental Health Association of New York/Asian LifeNet***	3,599	X											
Interviews with 9/11 case management programs & community-based mental health professionals	21			X	X	X	X	X	X	X	X	X	
Project Liberty *	2,404	X	X	X	X								
Appendices													
American Red Cross	315	X	X	X	X	X	X	X	X	X			
September 11th Fund		X	X	X	X	X	X	X	X	X			
Mental Health Association of New York/Asian LifeNet***	3,599	X											
Interviews with 9/11 case management programs & community-based mental health professionals	21			X	X	X	X	X	X	X	X	X	
Federation review of capacity count					X	X	X	X					
List of Federation-compiled Asian victims' demographics (from <i>The New York Times</i> , <i>CNN</i> , <i>MSNBC</i> , and www.september11victims.com)	184	X	X										
Census 2000													
Metropolitan Transit Authority													
Project Liberty *	2,404	X	X	X	X								

* All Project Liberty data covers October 2001 - September 30, 2002; Total N = 13,859

** American Red Cross data covers September 2001 - February 2003.

***Asian LifeNet data covers January 2001 - June 2002.

Appendix B:

September 11th-Related Mental Health Initiatives

A. The American Red Cross: Mental Health and Case Management Services

In the aftermath of September 11th, the American Red Cross has played a major role in providing disaster relief to victims' families, rescue workers, displaced residents, the injured, as well as economically affected individuals. In particular, the American Red Cross has implemented a number of programs to assist victims' families.

1. Family Gift Program

On September 23, 2001, the American Red Cross launched the Emergency Family Gift Program, and on January 31, 2002, expanded the program to cover expenses for up to one full year¹¹⁰. This program was launched to help families of the deceased and seriously injured meet their immediate financial needs. This gift program assesses each family's needs and provides a grant for living expenses such as food, clothing, utilities, mortgage or rent payments, funeral and related expenses.

2. September 11th Long-Term Recovery Program

On August 22, 2002¹¹¹, the American Red Cross launched this program to allocate more than \$133 million to provide services over a period of three to five years to victims' families. These funds are to be used to help pay for mental health and uncovered health care services, as well as family support assistance. In particular, working closely with The September 11th Fund, the American Red Cross plans to spend up to \$40 million over the three to five year life of the program in providing mental health services to 16,000 individuals. Services included are individual, group and family counseling; medication; hospitalization; and inpatient and outpatient substance abuse treatment. The program covers a maximum of 32 outpatient visits.¹¹²

- **Mental Health Program:** Administered by the Mental Health Association of New York City, this program allows eligible participants the flexibility of choosing their own licensed mental health provider. LifeNet, a nationwide toll-free telephone number (1-800-LIFENET) staffed by the Mental Health Association of New York City screens callers and routes those eligible to American Red Cross staff. Enrollment may be initiated by an individual or family member, through Service Coordinators, Family Support Specialists, or the American Red Cross call center. A toll free number for

¹¹⁰ American Red Cross, September 2002.

¹¹¹ Prior to this date, and subsequent to September 11, 2001, service providers could bill directly for approved services.

¹¹² Services are billable retroactively to September 11, 2001. Eligible clients and licensed mental health service providers may submit claims for reimbursement to the American Red Cross. Additional benefits are assessed on a case-by-case basis.

Asian LIFENET (1-877-990-8585), which is part of the LIFENET system, is designed to serve Asian-speaking callers. Only Chinese and Korean languages are available through Asian LIFENET.

- Family Support Services: Another component of the American Red Cross' long-term recovery program, this program, which intends to serve 3,000 families, provides individualized support and guidance to eligible families to ensure their access to the resources they need for their recovery. Trained American Red Cross Family Support Specialists assist with determining health care and mental health needs, identifying resources, making referrals, providing assistance through three financial assistance programs, identifying long term needs, and planning for the future.

3. Community Coordination

In its relief activities, the American Red Cross has worked closely with other relief agencies, community organizations, and government agencies. The American Red Cross conducts direct outreach through community liaisons for 1) New York, 2) New Jersey, and 3) regionally, or in the rest of the U.S. The American Red Cross is a member of the 9/11 United Services Group (USG), which coordinates 13 service agencies to help ensure that those affected by the events of September 11th get the help they need.

- Community Relations: The Community Relations department handles outreach to community-based organizations and advocacy groups, and the mental health team conducts direct outreach to mental health providers, including Project Liberty.
- State Relations: The American Red Cross works with the State Crime Victims' Compensation Board to coordinate outreach efforts on the state level.
- National Relations: On the national level, it works with the National Center for Victims of Crime.

4. Asian Community Outreach

In July 2003, the American Red Cross was planning targeted mental health outreach to Chinatown.

- Asian Language Services: American Red Cross reported that the Mental Health Department, which conducts outreach to and provides benefits training for community service providers and determines client eligibility for services, has no fluent Asian language-speaking staff. There is only one Cantonese-speaking staff at the call center. A translation service formerly was used at both the call center and within the mental health department when needed. In January 2002, the call center stopped using the translation services because it costs \$4.50 per minute. American Red Cross reported that it would be feasible to seek out and work with English-speaking family members as representatives of clients that do not speak English. According to providers, such a situation could interfere with making the appropriate referral as confidentiality is minimized.

B. The September 11th Fund

1. Mental Health Services

In conjunction with the American Red Cross, The September 11th Fund launched their joint mental health initiative in late August 2002. The Fund plans to spend up to \$45 to 65 million over the three to five year life of the program. Under this initiative, up to \$3000¹¹³ in services are offered to individual victims' family members¹¹⁴ in outpatient mental health treatment, including individual, group, and family counseling; psychotropic medications; alcohol or substance abuse detoxification, counseling, or outpatient rehabilitation and inpatient hospitalization and/or substance abuse treatment. Similar to the American Red Cross program, Mental Health Association/LifeNet serves as the front door for The September 11th Fund; eligibility is confirmed by the American Red Cross or the Mental Health Association and only licensed professionals may provide treatment. Once eligibility is confirmed, a benefit card and information are provided to help clients and providers submit claims. The American Red Cross and The September 11th Fund are sharing the costs of this program to maximize resources and avoid duplication of efforts.

2. Case Management Program

In late August 2002, The September 11th Fund launched a comprehensive case management program to provide assistance to victims' families, the injured, dislocated workers and displaced residents. Major services include comprehensive needs assessment; provision of information and referrals to mental health counseling and support groups; assistance in accessing legal services, immigration services, job training and job placement; assistance in applications; advocacy with service providers; and keeping clients up-to-date on the latest available services and benefits.

Specifically, this initiative enables six partner agencies - Asian American Federation (AAFNY), Chinatown YMCA, Chinese-American Planning Council (CPC), Filipino American Human Services, Inc. (FAHSI), and New York Asian Women's Center (NYAWC) - to hire bilingual case managers to reach out and work closely with Asian victims' families and economically impacted individuals.

- **Asian Language Services:**

Within The September 11th Fund program, services are provided in the following languages:

- Bengali – NYAWC
- Cantonese – AAFNY, C-YMCA, CPC
- Fuzhounese – C-YMCA
- Gujarati – NYAWC
- Hakka – CPC
- Hainanese – CPC
- Hindi – AAFNY, NYAWC, SACSS
- Japanese – JASSI
- Korean – AAFNY
- Mandarin – AAFNY, C-YMCA, CPC
- Marathi – AAFNY
- Tagalog – FAHSI
- Tamil – AAFNY
- Toisanese – CPC

¹¹³ Services are billable retroactively to September 11, 2001. Eligible clients and licensed mental health service providers may submit claims for reimbursement to The September 11th Fund.

¹¹⁴ Compared to the American Red Cross, The September 11th Fund also offer these mental health services to a wider range of groups, including injured victims and their family members, former employees of WTC and their family members, dislocated workers who worked in the WTC vicinity and their family members, rescued workers and their family members, displaced residents, and children who attended a nearby school.

- Urdu – NYAWC
- Vietnamese – CPC

The range of languages covered plays a crucial role in creating linkages to much-needed services. Within the one-year period for which funding for this initiative is available, the challenge of the program is to connect victims' family members and others indirectly impacted to services and information that will sustain them for the long-term. As mentioned, the effects of trauma can persist for years if addressed inadequately or not at all, and often may surface years after the traumatic event. Clients need to be furnished presently with supportive and preventive tools, such as mental health education to build self-awareness as well as knowledge about available and appropriate resources.

- **Asian American Victims' Families' Mental Health Service Utilization**

Interviews were conducted in December 2002 and January 2003 with case managers from these six partner agencies. Consistent with findings from the interviews with victims' family members in this study, case managers reported that generally very few clients who were victims' family members expressed interest in mental health services. Of those who did, very few found the sessions helpful because they did not see a provider of the same cultural background. Generally, most Asian American clients were more interested in obtaining concrete assistance than mental health assistance. However, a greater degree of willingness to utilize mental health services was observed among Asian American clients who were more acculturated and did not have any special language needs, were more educated, and had higher household incomes.

Case managers consistently acknowledged that the method of broaching the topic of mental health with Asian American victims' families requires extra care and cultural sensitivity. Often, the issue of mental health is not addressed until the second or third meeting, or when a relationship has become more established with the client. In other instances, the issue is not directly raised at all, and instead, other gauges are employed, such as, for example, asking how the children are doing.

Currently, mental health training is not a requirement of The September 11th Fund case management training program. For case managers who come into the job with little or no mental health background, broaching the topic of mental health and eliciting discussion about mental health issues can be a challenge. Especially for those who work directly with impacted immigrant groups, the need for mental health training that emphasizes cultural competence is critical.

The following describes interview findings from these partner agencies:

- **Asian American Federation (AAFNY)**

Under this initiative, the Asian American Federation's focuses its outreach and services on the Chinese, Korean, and South Asian families of direct victims, as well as other affected community members in Queens.

Asian American Federation employs six full-time case managers, who collectively speak Cantonese, Hindi, Korean, Mandarin, Marathi, and Tamil. Of the over 20 family members served, only four expressed interest in mental health services. These families are generally more interested in concrete assistance. Those who did receive mental health services did so through Project Liberty, through the assistance of American Red Cross. The perceived utility of these visits was limited, largely due to the lack of culturally competent care.

- **Chinatown YMCA**

Chinatown YMCA serves Chinese American children and families in Chinatown and the Lower East Side. The program employs five full-time case planners who serve about 15 to 18 clients each and among them speak Cantonese, Mandarin, and Fuzhounese. The case planners assist individuals in accessing services and financial assistance. Though Chinatown YMCA refers many clients to job training programs (e.g., CPC, Manpower, Henry Street Settlement, and University Settlement) and entitlement programs (e.g., Safe Horizon, Salvation Army, Lower Manhattan Development Corporation, and public assistance from the government), few clients ask directly for mental health services. For those who require some form of mental health help beyond counseling and support groups, referrals are made to Lower Eastside Service Center and Hamilton-Madison House. Referrals are accepted from schools in the Lower East Side and Administration for Children Services.

- **Chinese-American Planning Council (CPC)**

CPC 9/11 Case Management serves Chinese Americans in Chinatown and Brooklyn. The program staffs nine full-time case managers, who collectively speak Cantonese, Mandarin, Hakaanese, Hainanese, Vietnamese, and Toisanese. Each case manager has a caseload of approximately 50 clients. Relief services offered within CPC include translation, application assistance, employment services, referral services, small business assistance, and mental health referrals. Mental health counseling is usually not discussed in the first meeting with the client or before a level of comfort or a relationship has become more established. However, after the second or third meeting, or as the case manager feels appropriate, referrals are made to Charles B. Wang Community Health Center or Asian LifeNet. Most CPC clients come through word-of-mouth, although CPC has done outreach at Community Board meetings and Safe Horizon.

- **Filipino American Human Services, Inc. (FAHSI)**

As of December 5, 2002, FAHSI, which serves Filipino American families and workers, had 12 September 11th-impacted cases, six of whom were victims' family members. All of these victims' family members were offered mental health counseling; Four of them actually received services. The two who opted not to seek mental health services preferred to talk to priests. In these cases, referrals were made to Project Liberty, Safe Horizon, Choice Mental Health Center (Woodside, Queens), and an in-house counselor, who is a psychiatrist trained in the Philippines. According to FAHSI, mental health appears to take as much priority as concrete issues, and clients report that these issues are intertwined.

FAHSI's Filipino American clients represented a generally more acculturated immigrant group. All victims' families were American citizens and had been in the U.S. for more than 10 years. Nearly all of those who received mental health services were college-educated women. All of these individuals spoke English, but two of them preferred to communicate in a Filipino dialect. None had any experience with mental health counseling prior to the loss of their family member.

FAHSI conducts outreach through community forums and letters to the families from a list of victims' families in the United Services Group (USG) database. It also receives referrals by other agencies; The organization is reportedly working with Safe Horizon, Catholic Charities, American Red Cross, New York Unmet Needs Roundtable, and Bridge Fund of New York to provide all forms of available assistance to victims' families.

- **Japanese American Social Services, Inc. (JASSI)**

JASSI's Relief, Recovery and Rebuilding Initiative for September 11th support and services has sponsored three workshops, held five support group sessions, and translated September 11th-related information into Japanese.

JASSI's outreach includes ads printed in Japanese newspapers and posters in Japanese stores. It has issued five press releases and numerous articles in local papers about its work providing September 11th support services. The organization has also conducted a community survey with 150 respondents and determined that many people wanted information on counseling and self-care, government benefits, environmental issues and immigration issues.

Its one Japanese-speaking caseworker has been in contact with over 100 people and worked with a total of 20 clients, about six of them ongoing, to access benefits. Clients generally ask for concrete services (e.g., financial consultations, Mortgage and Rental Assistance, entitlements, and other assistance), and not mental health services. Though the caseworker offers them pamphlets about the various English and Japanese counseling services available at Project Liberty and Hamilton-Madison House, it is not known if the clients take advantage of the sessions.

- **New York Asian Women's Center (NYAWC)**

Under this initiative, The New York Asian Women's Center serves South Asian Americans. Case managers speak Bengali, Gujarati, Hindi, & Urdu. The center receives clients from referrals by other agencies; namely, Safe Horizon and South Asian organizations. At the time of the interview, NYAWC had not conducted its own outreach.

Similar to FAHSI clients, the family members that were linked to mental health services were generally more acculturated women. All of them were professionals, American-born, and did not have any special language needs. The immigrant victims' family members were not interested in mental health. They preferred their family, friends and community to be around them, rather than in a clinical setting.

For victims' families, economic issues generally took precedence over mental health, even among those who received counseling. The services that clients sought were typically individual and short-term.

- **South Asian Council for Social Services (SACSS)**

SACSS' clientele was initially more interested in concrete services, such as legal assistance from Trial Lawyers Care (TLC) and immigration assistance. SACSS noted that most clients are usually looking for several forms of assistance. After clients have their basic needs addressed, they are more open to receiving mental health services, provided they are from a culturally relevant source. SACSS stressed the importance of culturally competent care for building rapport with the client.

Of the 44 victims' families in the case management program, between 80 and 100 people are served in the mental health program. This high level of service utilization is attributable to positive experiences, spread by word of mouth, of an initial few. All the mental health counseling is done in-house by three licensed mental health practitioners. Both individual and group sessions are offered, with monthly group sessions in New Jersey and home-based programs in Westchester. Support groups are comprised mostly of spouses, who have connected through other recreational group activities as well. SACSS reported that parents are the most emotionally impacted and usually prefer to receive individual counseling. Services are offered in

Bengali, English, Gujarati, Hindi, and Malayalam.

3. School-based Initiative

On September 19, 2002, The September 11th Fund launched a program to help an estimated 25,000 pre-school through high school students who experienced the terrorist attacks firsthand or were traumatized by the subsequent evacuation or relocation from their schools. Under this \$13 million initiative, the Fund augments mental health services, art therapy, enrichment activities such as summer school and after-school programs, academic preparation assistance, and professional development to help train teachers and others to identify and respond to mental health problems in children. Community School District 2 and School Arts Rescue Initiative Project are among the major grant recipients of this initiative.

Asian Community Impact: Community School District 2 has received funding to hire 17 case managers in schools located in Lower Manhattan. Included in these schools are the following predominantly Asian schools: PS 1, PS 2, PS 42, PS 124, PS 126, PS 130, MAT, and MS 131. While the coordinator at the District initially hoped to hire bilingual case managers, this was not possible due to the inability to find such qualified individuals. In this absence, they have provided cultural awareness workshops for these case managers, conducted by university-based mental health experts. Under this program, the District also provides therapeutic services such as art therapy in two of the Chinatown schools, PS 42 and PS 124.

The School Arts Rescue Initiative Project received funding to provide art therapy to schools in Lower Manhattan. All Community School District 1 and 2 schools, as well as the archdiocese schools - including the two predominantly Asian American schools (Transfiguration and St. Joseph) - have also received funding. Schools choose from a number of the New York Times Fund's designated art organizations that provide therapeutic services, some of which are culturally-sensitive.

C. Mental Health Association of New York City/LifeNet

The Mental Health Association, under contract with the New York City Department of Health and Mental Hygiene, sponsors LifeNet, a program that, in addition to providing public education and outreach, operates a 24-hour crisis information and referral hotline. *AYUDESE* (Spanish LifeNet) and Asian LifeNet are its other-language subsidiaries. Asian LifeNet is staffed by professionals with language capacities in Cantonese, Mandarin, and Korean.

As New York City's largest mental health service network, LifeNet was the only service after September 11th that had an existing communications infrastructure to deal with a crisis of that magnitude. LifeNet serves as the front door in the coordinated response of the major mainstream mental health initiatives. For the American Red Cross and The September 11th Fund program, LifeNet shares the responsibilities of service eligibility determination and referral-making with the American Red Cross¹¹⁵. Similarly, Project Liberty designated LifeNet as the major entry point for access to its services¹¹⁶.

¹¹⁵ As of August 2002.

¹¹⁶ As of the early weeks following September 11th.

D. Project Liberty: Crisis Counseling, Public Education, and Referrals

As of mid-August 2002, Project Liberty has provided counseling and public education services to more than 150,000 individuals who live or work in New York City. Project Liberty was initiated in October 2001 with a \$22.7 million statewide grant from the Federal Emergency Management Agency (FEMA). New York City received \$14 million to establish Project Liberty counseling services in all five boroughs. In May 2002, FEMA awarded New York State an additional \$112 million to continue the program.

Short-Term & Long-Term Services: Project Liberty staff offers free short-term crisis counseling and education services within the New York state area. It can also refer to long-term mental health specialists.

Asian Community Outreach: As of October 2001, Hamilton-Madison House, the largest mental health service provider in the New York City Asian American community with a staff speaking over 22 Asian languages and dialects, performed extensive outreach in the New York metropolitan area. In the subsequent year, Project Liberty performed over 10,000¹¹⁷ contacts with Asian American clients.

Other Project Liberty providers currently serving the Asian American community in Manhattan include Bellevue Hospital, Educational Alliance, Gouverneur Hospital¹¹⁸, Henry Street Settlement, Saint Vincent's Hospital, and University Settlement. In the first six months after September 11th, a Project Liberty program was established at the 141 Worth Street FEMA relief center in Manhattan¹¹⁹. Outside of Manhattan, Project Liberty operates through community-based service providers in other areas with high concentrations of Asian Americans, such as Flushing, Queens and Sunset Park, Brooklyn.

E. Other Initiatives

1. Asian Americans for Equality Wellness Project

In February 2002, AAFE commenced its one-year, \$125,000 Wellness Project to provide mental health-related services and case management to Asian Americans who suffer from mental health issues as a result of September 11th. The program's focus is mental health prevention, coping, and maintaining emotional health. Linking mental health services with other concrete services, such as AAFE's ESL classes and legal assistance programs, reduces the stigma associated with receiving mental health services. The program also runs public mental wellness education workshops in a Chinatown library.

The Wellness project staffs one supervisor and two licensed direct service providers who are bilingual in Cantonese and Mandarin. As of December 2002, 1000 people had been screened. In December, there were 68 open cases, all of whom had received brief counseling. The most common issues are stress management, depression, and anxiety. Referrals are made to Bellevue Hospital, Gouverneur Hospital, and homeless shelters, as necessary.

¹¹⁷ Can be follow-up visits or duplicate counts.

¹¹⁸ From September 12, 2001 to October 2002, Gouverneur conducted approximately 80 intakes with Asians Americans. Roughly 10% of cases were made up of Asian-Pacific Islanders, though it should be noted that more than 10% of those who sought services were of Asian-Pacific Island descent. The language capacities of both sites were extremely limited, and most people were turned away because of language barriers. Asian language capacity was in Chinese only; In Gouverneur: there were 15 Mandarin, 10 Cantonese, and one Taiwanese staff.

¹¹⁹ From October 2001 to January 2002, the FEMA Center at 141 Worth Street conducted 120 Project Liberty intakes with Asian Americans. At 141 Worth Street, there were four Chinese (i.e., Mandarin and Cantonese) speaking staff. The Project Liberty program at this relief site closed after January 2002.

2. Charles B. Wang Community Health Center

With three locations (Canal Street & Walker Street in Manhattan; 37th Avenue in Flushing), the Charles B. Wang Community Health Center's Action for Bridge Program assists many Asian Americans with physical and mental health issues while providing culturally competent services. The Clinic hosts a variety of outreach and educational programs about general wellness and specialty healthcare issues. Major funders of the Bridge program are: The Robert Wood Johnson Foundation, van Ameringen Foundation, Pfizer Foundation, United Hospital Fund, New York Community Trust, and Sergei Zlinkoff Fund.

Since 1997, the Clinic has been providing primary care and mental health services through its Bridge program, which integrates mental health screening into primary care visits. This link reduces the stigma associated with mental illness and can promote better outcomes for primary care patients who otherwise would not visit a mental health setting. The program trains primary care practitioners in mental disorder assessment, diagnosis, and management, with an emphasis on cultural competence. It also provides mental health education to community members.

September 11th-related outreach (funded largely by Project Liberty) started in February 2002 and centered around the Chinatown area. The Charles B. Wang Community Health Center outreaches to public schools, conducts radio programs, and distributes Chinese printed pamphlets at street fairs. The focus of the outreach is on helping children and elderly deal with post-September 11th trauma and stress. The Robert Wood Johnson Foundation, Sergei Zlinkoff Fund, Commonwealth Fund, van Ameringen Foundation, and New York Community Trust provided additional funding to support mental health services. Staff at the Charles B. Wang Community Health Center speak the following Chinese dialects: Cantonese, Mandarin, Toishanese, Shanghainese, and Taiwanese.

3. Coalition for Asian American Children and Families – Project CORE (Children Overcoming through Resources and Education: A Community Mental Health Initiative)

In October 2002, the Coalition for Asian American Children and Families (CACF) implemented the CORE initiative (Children Overcoming Through Resources and Education), with the aim of fostering positive mental health outcomes for children and families primarily in Community School Districts 1 and 2. Through community-based events featuring educational and recreational activities that promote coping and healing, the program's preventive, holistic framework emphasizes themes of positive identity, re-establishing normalcy and a sense of safety, pro-social behavior, developing relationships, and community-building. This initiative includes an extensive public education campaign providing mental health education for parents. It is also developing culturally competent mental health curricula and offers training to community-based service providers.

4. Lutheran Family and Community Services New Life Center

Established on December 12, 2002, the New LIFE (Lutheran Initiative for Empowerment) Center serves the entire Asian immigrant population, particularly Fujianese families and individuals. In the aftermath of September 11th, many Fujianese lost their homes and/or jobs and could not qualify for assistance. They were excluded by the strict geographical guidelines set forth by many agencies. There are few programs and services available in Fujianese population, leaving the population without adequate translation and disaster support services.

Some of New Life Center's services are job-training; help accessing public assistance; immigration services; counseling and support groups; and referrals to other programs.

Fees for immigration legal services vary (but have a minimal charge), and counseling and other services are free. Currently there are two full-time staff members, one of whom is of Fujianese background.

5. New York State Crime Victims Board

New York State Crime Victims Board offers a victim assistance program that provides immediate help to victims of crime. This program provides substantial financial relief to victims of crime and their families by paying non-reimbursed crime-related expenses, including medical and funeral expenses, loss of earnings or support, counseling, crime scene clean-up expenses, the cost of repairing or replacing items of essential personal property, reasonable court transportation expenses, and the cost of residing at or utilizing the services of a domestic violence shelter. It reimburses the cost of psychotherapy not covered by insurance to those who were directly affected by the attack.

6. The Robin Hood Foundation

The Robin Hood Foundation has provided mental health funding to a number of community organizations in the Asian American community. In particular, the Foundation provided funding to Asian Americans for Equality for two bilingual social workers for mental health and case management services; Filipino American Human Services, Inc., for a social worker to conduct individual and group mental health services; and South Asian Council for Social Services, for outreach and professional staff. More recently, the Foundation has funded the Lower Eastside Service Center to reach out to undocumented immigrants residing in Chinatown who have been adversely affected by the consequences of September 11th.

7. WTC United Family Group

WTC United Family Group holds periodic support groups in New York and New Jersey for family and friends of victims. Groups are led by non-professional mental health advisors or family members. The WTC United Family Group also offers online support groups. However, there are no Asian American support groups.

Appendix C:

Program Capacity of Chinatown Community-Based Organizations and Other Asian Services Programs in Manhattan

1. Bellevue Hospital Center – Asian Inpatient Program

The following services are offered: individual therapy sessions, group therapy, activity therapy, and medication.

- Languages and dialects: Cantonese, Mandarin, Toishanese, Korean, Vietnamese, and Tagalog
- Bilingual staff: 7 full-time and 4-5 part-time staff members
- Maximum capacity for Asians: 25
- Children: approximately 15 maximum capacity
- Elderly: approximately 31 maximum capacity

2. Charles B. Wang Community Health Center (CBWCHC)

The CBWCHC provides comprehensive primary and specialty health care that is culturally competent and affordable; emphasizes health promotion and disease prevention through education and outreach; advocates on behalf of the community for better access to care; and aids in the training of future Asian American healthcare providers for community service.

- Languages and dialects: Cantonese, Mandarin, Toishanese, Shanghainese, and Taiwanese
- Bilingual staff: 3 social workers, 1 psychiatrist, and 1 part-time social worker intern
- Maximum capacity: 25
- Children: 10 maximum capacity
- Elderly: 15 maximum capacity (elderly are subsumed under adult category)

3. Educational Alliance

Mental health services are offered in an outpatient clinic setting to children, adolescents, adults, and seniors. The following services are offered: clinical assessments, psychological and psychiatric consultations, individual, and family and couples treatment. Groups such as psychotherapy, parenting, bereavement, wellness and caregiver are also offered. Mental health services are provided for students in local schools.

- Languages and dialects: Unknown
- Bilingual staff: 1 social worker
- Maximum capacity for all cases, including children and elderly: 30

4. Gouverneur Hospital – Asian Bicultural Clinic

Staffed by a bicultural/bilingual Chinese interdisciplinary team of mental health professionals, the clinic provides comprehensive mental health care, including psychiatric treatment, pharmacotherapy, individual, group, and family therapy, patient and family psycho-educational groups, liaison services for those who need psychiatric hospitalization, and family support groups.

- Languages and dialects: Cantonese, Mandarin, and Toishanese
- Bilingual staff: 7

5. Gouverneur Hospital for Older Adults

Gouverneur Hospital provides individual therapy, group therapy, screening/evaluation, home visits, outreach and psychoeducation to mentally ill seniors.

- Languages and dialects: Cantonese, Mandarin, Toishanese, Korean, and Tagalog

6. Hamilton-Madison House – Mental Health Program

Hamilton-Madison House provides behavioral health services for the Asian American community with specific targets for the Chinese, Japanese, Korean, and Southeast Asian populations. Mental health services include individual, group, and family therapy, crisis intervention, psychiatric consultation, and an alcoholism clinic. The Supported Housing program provides independent housing for 23 Asian inpatients recently transitioned from mental health institutions. Services include bilingual/bicultural case management, entitlement and financial consultations, community information and resources, daily living skills, job-related training, and recreational and social activities. Family and senior services, as well as a refugee program are available. Hamilton-Madison House is also involved in community-based advocacy, organizing and educating around local and larger issues of concern.

- Languages and dialects: Cantonese, Fuzhounese, Mandarin, Toishanese, Japanese, Khmer, Korean, and Vietnamese
- Bilingual staff: 55
- 800 patients per year – primarily Chinese
- Children: 25 maximum capacity
- Elderly: subsumed under adult programs

7. Henry Street Settlement – Community Consultation Center (CCC)

Henry Street Settlement is comprised of four transitional residences for the homeless, a battered women's shelter, a mental health clinic, a senior center, a multi-disciplinary arts center, services to homebound New Yorkers, a day care center, and a broad spectrum of educational, recreational, and vocational programs for youth. Its Asian Bicultural Unit offers counseling and day treatment.

- Languages and dialects: Cantonese and Mandarin
- Bilingual staff: 17

8. Lower Eastside Service Center (LESC)

LESC has provided specialized treatment services to meet the needs of the Chinatown community for many years. Currently, Chinese language mental health services are available in the following programs:

Continuing Day Treatment Program - Provides psychiatric rehabilitative treatment five days per week and four hours per day.

Family Support Services - The staff of the Chinese Program work closely with family members to educate them about mental illness and to provide mental health support.

Pre-Vocational Workshop - In addition to time spent in the program, clients may participate in the Pre-Vocational Workshop, which emphasizes the development of arts and crafts skills as the basis for learning the skills necessary to (re-)enter and remain in the world of work.

Individual Treatment - Individual psychiatric treatment on a once-weekly basis is also available.

- Languages and dialects: Cantonese, Fuzhounese, Mandarin, and Toishanese
- Bilingual staff: 1 full-time and 2 part-time case managers
- Maximum capacity: 75 to 85 for the year
- Children: no such program
- Elderly program: subsumed under the adult program
- A special mental health program serving the chronically ill, undocumented immigrant population has the capacity for 100 cases

9. University Settlement

Home Based Crisis Intervention (HBCI) Program provides intensive family-centered, therapeutic and supportive services to SED children and youth who are at imminent risk of hospitalization. The children's case management program has provided a comprehensive array of services to children with complex mental health needs. Children and adolescents (ages 5 to 18) who are at risk of psychiatric hospitalization or residential placement are referred by mental health providers, parents, hospitals and schools. Bilingual and bicultural case managers offer an average of four home visits per month. Through home visits, families are provided with ongoing assistance and advocacy in order to access the mental health, education and income support programs essential to meeting their child's needs. A range of recreation and socialization activities are also provided.

- Languages and dialects: Cantonese and Mandarin
- Bilingual staff: 2
- Maximum capacity for Asians: 40
- Children: approximately 18 cases
- Elderly: approximately 1-3 cases

Appendix D: Demographic & Community Profiles

A. WTC Asian Victims Demographic Profile

Of the 2,743 estimated World Trade Center deaths, 6.7%, or 184 victims, were of Asian descent. The number of Asian deaths was the fourth largest racial category, preceded by non-Hispanic whites (76%), Hispanics (10%), and African Americans (8%)¹²⁰. Reflecting one of the broadest racial groups, comprised of 15 different ethnocultural subgroups, the Asian demographic profile paints a picture reflective of the overall diversity of this racial category.

1. Ethnicity

Fifteen ethnicities were represented in the Asian victim population. South Asians¹²¹ represented nearly half (43%) of those for whom ethnicity was identifiable.

- Among all Asians, the greatest number of victims by ethnicity, 46, was of Indian descent, representing one-quarter of Asian deaths.
- Chinese represented the second largest ethnic group, with 36 victims, or approximately 20% of Asians deaths.
- Japanese represented the third largest ethnic group, with 23 victims, or 13% of Asian deaths.
- Korean represented the fourth largest ethnic group, with 16 victims, or 9% of Asian deaths.

These percentages generally correspond with ethnic breakdowns among the Asian American population in New York City, with the exception of the Chinese, who represented 20% of the deceased Asians, but 40% of the Asians overall in New York City in the Census data.

¹²⁰ *Summary of Vital Statistics, 2001*, The City of New York, Bureau of Vital Statistics, New York City Dept. of Health and Mental Hygiene, March 2003.

¹²¹ The South Asian number includes: Bangladeshi, Asian Indian, South Asian/Indo-Caribbean, Pakistani, and Sri Lankan.

Figure 1: Ethnicity of Deceased Asian Victims

Ethnicity of Victim	Number of Deceased Asian Victims	Percent of Deceased Asian Victims
Asian Indian	46	25.00%
Bangladeshi	6	3.26%
Burmese	1	0.54%
Chinese	36	19.57%
Filipino	12	6.52%
South Asian/Indo-Caribbean	13	7.07%
Indonesian	1	0.54%
Japanese	23	12.50%
Korean	16	8.70%
Malaysian	2	1.09%
Pakistani	7	3.80%
Sri Lankan	1	0.54%
Taiwanese	4	2.17%
Thai	2	1.09%
Vietnamese	1	0.54%
Unknown/Other Asian	13	7.07%
Total	184	100.00%

Sources: The New York Times, CNN, MSNBC, www.september11victims.com

2. Residence

While the locales of residence spanned nationally as well as globally, the overwhelming majority of victims resided locally. Residence was unknown for 10%, or 18, of the Asian victims.

Of the 166 victims for whom residence was known:

- 37% (62) resided in New York City¹²²;
- 13% (21) resided in New York State, but outside of New York City;
- 42% (69) resided in New Jersey;
- 7% (11) resided in other states; and
- 2% (3) resided internationally.

In terms of percentage of population, the general victim population tended to reside in New York City to a greater degree, and in other states to a lesser degree, as compared to the Asian victims' group¹²³.

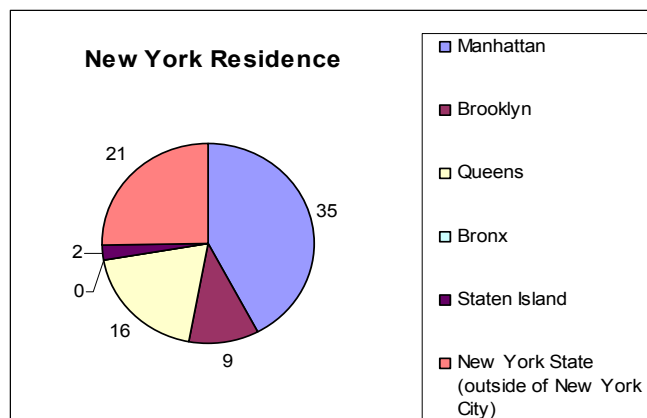
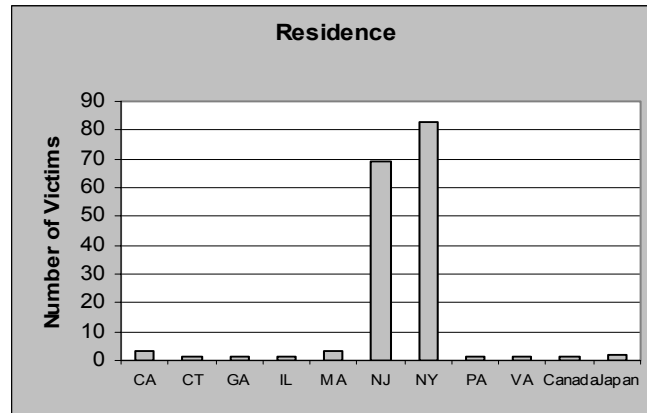
For the general victim population:

- 43% lived in New York City¹²⁴;
- 20% resided in New York State, but outside of New York City;
- 25% resided in New Jersey;
- 35% resided in other states;
- Less than 1% resided internationally.

¹²² Of the Asian victims who resided within New York City, 56% (35) resided in Manhattan; 26% (16) resided in Queens, 15% (9) resided in Brooklyn, 3% (2) of the Asian victims resided in Staten Island, and 0% (0) resided in the Bronx.

¹²³ *Summary of Vital Statistics, 2001*, The City of New York, Bureau of Vital Statistics, New York City Dept. of Health and Mental Hygiene, March 2003.

¹²⁴ Of the total victims' population within New York City, 32% (340) resided in Manhattan, 27% (292) resided in Brooklyn, 18% (194) resided in Staten Island, 14% (157) resided in Queens, and 9% (93) resided in the Bronx.

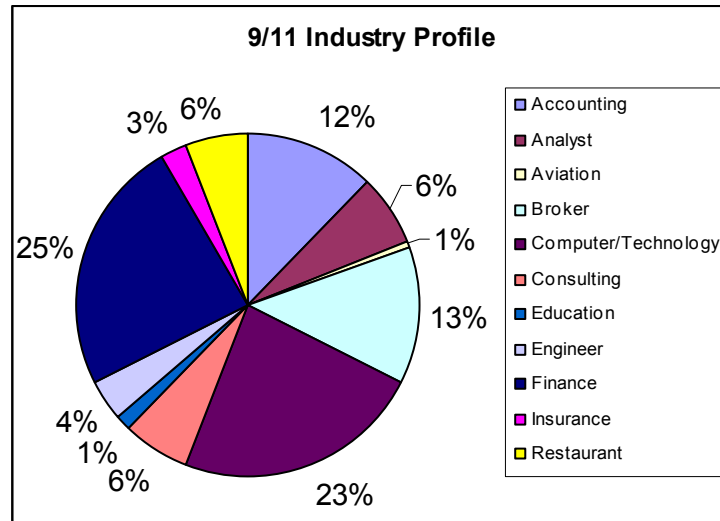
Figure 2: Residence of Deceased Asian Victims

3. Occupation or Occupational Industry

The victims' diversity also stemmed from their varied experience and industry background. Of those for whom occupational industry was known, the majority were employed in the finance and technology industries. Occupational industry was unknown, however, for 16%, or 30, of the Asian victims.

Of the 154 victims for whom occupation or occupational industry was known:

- 25%, or 37 victims were employed in the finance industry;
- 23%, or 36 were employed in the computer technology industry;
- 12%, or 19 were employed in the accounting industry;
- 6%, or 9 were in the restaurant industry;
- Other fields include education and insurance.

Figure 3: Occupation or Occupational Industry¹²⁵ of Deceased Asian Victims

4. Gender

Men were represented more than twice as much as women in the victim population. Gender was unknown for 4, or 2%, of the Asian victims.

Of the 180 victims for whom gender was known:

- 69%, or 125 were male;
- 31%, or 55 were female.

In the general victims' population, men were represented to a greater degree than they were in the Asian population, comprising approximately 76% of the victims, while women comprised approximately 24%.

Figure 4: Gender of Deceased Asian Victims

¹²⁵ More specific industry information on occupation categories in the data set, such as "Broker," "Analyst," and "Consultant," was not available, so industry (e.g., Finance) totals may actually be higher.

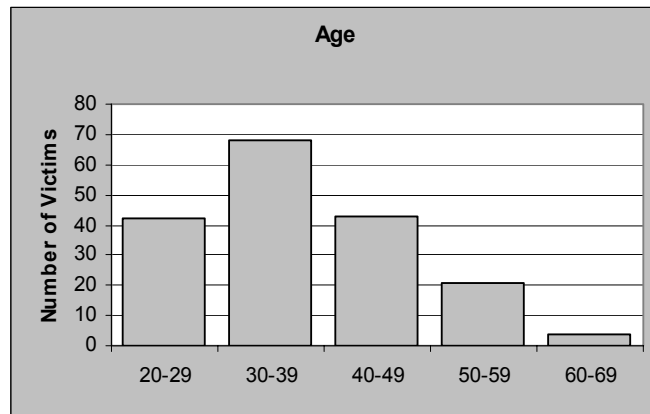
5. Age

The largest age bracket of victims for whom age was known were between the ages of 30 and 39. Age was unknown for 3%, or 6, of the Asian victims.

Of the 178 victims for whom age was known:

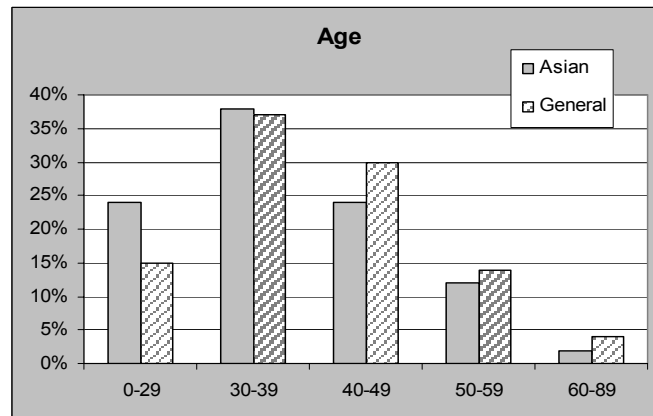
- 38%, or 68 victims were between the ages of 30 and 39;
- 24%, or 42 were between the ages of 20 and 29;
- 24%, or 43 were between the ages of 40 and 49;
- 14%, or 25 were over 50 years old.

Figure 5: Age of Deceased Asian Victims



In terms of percentage of population affected, the Asian victims were generally younger than the victims in the general population. In the general population, the largest age bracket, in which 37% of general victims fell, was 30 to 39, as it was for the Asian victims. The age brackets of 40 to 49 and over 50 were larger, however, in the general population, at 30% and 18% of the victims. The age bracket of 20 to 29 was the smallest, with 15% of the general victim population represented.

Figure 6: Age of Deceased Asian & General Victims Populations as Percentage of Group¹²⁶



¹²⁶ In the general victims' population, the span of ages was 0 to 89.

6. Marital Status

An overwhelming majority of victims for whom marital status was known were married. Marital status was unknown for 38%, or 69, of the Asian victims.

Of the 115 victims for whom marital status was known:

- 77%, or 88 were married;
- 23%, or 27 were not married.

Figure 7: Marital Status of Deceased Asian Victims



Clearly, the Asian victims' profile shares a story not only of diversity, but one of the many young talents that were lost as a result of the World Trade Center attacks.

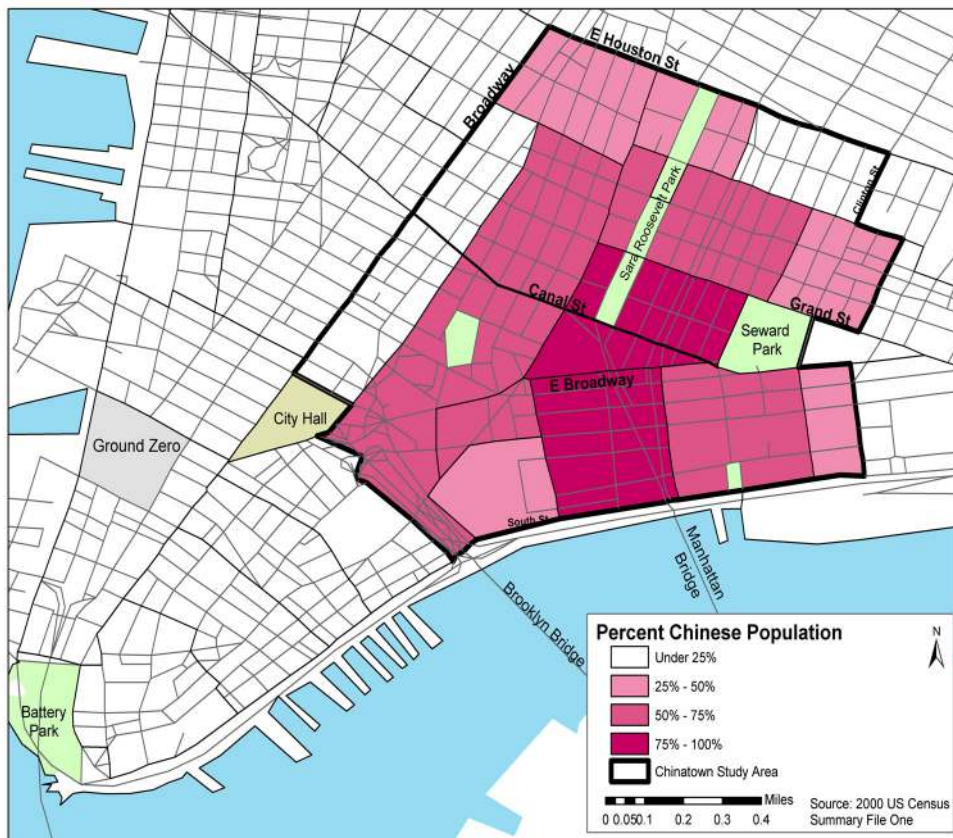
B. Chinatown

1. Demographic Profile

Using Census 2000 sample¹²⁷ data, this section provides a detailed demographic analysis and contextual overview of Chinatown's residential population prior to September 11, 2001. Consideration of contextual factors such as citizenship, income, and educational attainment is crucial towards understanding the nature and extent of mental health outcomes, the barriers to mental health services access, and factors associated with effective service delivery and utilization. This section also examines physical access and proximity to community mental health services as well as the accessibility of these services via public transportation. The overview highlights the socioeconomic, environmental, and service system factors that can hinder or promote mental health outcomes, service access, and quality of care.

With low levels of income, citizenship status, English proficiency, and educational attainment, neighborhood census data suggests an already challenged Asian population in Chinatown. As mentioned, low socioeconomic status (SES) is a major risk factor for negative mental health outcomes. Low SES not only predisposes the community to greater levels of economic and social stressors but restricts various forms of access (e.g., physical and financial) to mental health treatment. In the aftermath of September 11th, the community was further debilitated by the severe economic and emotional consequences of the tragedy.

Figure 8: Chinatown Study Area with Chinese Population Concentrations



Produced by the Asian American Federation of New York

¹²⁷ Specifically, the overview examines contextual factors using SF2 and SF3 Census 2000 data, which allow the definition of Chinatown's boundaries using block groups or Census tracts.

a. Citizenship Status

In 2000, the majority of Asians in Chinatown were foreign-born, and nearly half of these Asians did not have United States citizenship.

- 81% (44,125) were foreign-born.
- 48.1% (26,190) were foreign born and not United States citizens.
- 19% (10,376) were native-born.
- Between 1995 and 2000, 25% (12,571) of the foreign born population came from other countries into Chinatown.
- Between 1990 and 2000, 47% (23,782) came from other countries into Chinatown.

b. Poverty and Income Levels

In 1999, nearly one-third of the Asians in Chinatown lived below the poverty line, and the majority of children in poverty lived with a married couple.¹²⁸

- 31.4% (17,022) of Asians had an income below the poverty level in 1999.
- 80.7% (2,992) of children in poverty lived with a married couple.
- Nearly one in three (3,762) Asian elders lived in poverty.

In Chinatown, at least 40% of Asian families¹²⁹ and households¹³⁰ earned meager annual incomes.

- Nearly half of Asian households earned less than \$20,000.
- Over 60% of Asian elderly households earned less than \$15,000.
- Over 40% of Asian families earned less than \$20,000.

In addition, full-time, year-round Asian workers earned low annual incomes.

- Over 50% (58.9%, or 7,565) of full-time, year-round Asian workers earned less than \$15,000.
- Over a quarter of full-time, year-round Asian workers earned less than \$10,000.
- Per capita income was \$12,065.

c. Household Size

Asians living in Chinatown had relatively large households compared with the total population in Chinatown and New York City. This may be explained by the possibility that Asian households are comprised of multiple rent-payers. In light of the low incomes of Chinatown workers, multiple rent-payers may be necessary to alleviate the rent burden.

- The average household size for Asians in Chinatown was 3.14 people.
- The average household size for the total population in Chinatown was 2.71
- The average household size for the total population in New York City was 2.59.

d. Age

Of the 54,650 Asians in Chinatown, 18% of Chinatown's population were youth (under the age of 18); 66% were adults of working age (between the ages of 18 and 64), and 16% were elderly (age 65 or older). Specifically:

¹²⁸ According to the 2000 Census, a family of four in the United States was classified as poor if it had a cash income less than \$18,104 during the previous year. The official poverty level for a family of three was \$14,128. In New York City, where the cost of living is much higher than in most of the nation, many more families fell below the poverty threshold.

¹²⁹ A family is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

¹³⁰ A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. The count of households excludes group quarters. There are two major categories of households, "family" and "nonfamily".

- There were 9,837 youth, or residents under the age of 18, in Chinatown. Of these:
 - 1,453 (14.8%) were age 3 to 5 years;
 - 3,787 (38.5%) were age 6 to 12 years;
 - 3,164 (32.2%) were age 13 to 17 years.
- There were 35,932 adults of working age, or between the ages of 18 to 64.
- There were 8,891 elderly, that is, residents age 65 or older.
 - 5,104 (57.4%) were age 65 to 74 years
 - 3,777 (42.5%) were age 75 or older

e. Educational Attainment

Most of Chinatown's Asian population¹³¹ did not have a high school diploma, and nearly half of the adult population had less than a ninth grade education. Furthermore, women generally had lower levels of educational attainment than men.

- Nearly 70% of Chinatown's Asians 25 years and over did not have a high school diploma.
- Nearly half (48.1%) of the Asian population had less than a ninth grade education.
- Among the women in Chinatown, 72.5% (14,209) did not have a high school diploma, as compared to 66% (12,980) of Chinatown's males.
- Also, more than half the women (53.6%, 10,502) had less than a ninth grade education, as compared to 42.5% (8,362) of the men at this level.

f. Language/ English Ability

The majority of Asians in Chinatown had limited English language proficiency; most of these individuals were adults between the ages of 18 and 64¹³².

- Over half (58.9%, 30,764) of Chinatown's Asian population spoke English either "not well" or "not at all".
- Over 60% of those who were of working age (ages 18 to 64) had limited English proficiency.
- Nearly 80% (79%, 7,076) of the elderly population did not speak English well or at all.

g. Mental Disability

Chinatown had a significant concentration of Asian individuals with mental disabilities¹³³.

- 7.6 percent (3,662) of Asians in Chinatown had some kind of mental disability. This was significantly higher than the overall New York City Asian rate of 2.7 percent.
- Mental disability in Chinatown varied greatly with gender, as it was more prevalent among women (11.7%) than men (4.3%).

2. Physical Access to Mental Health Services

Other data from the community provide insight into this population's ability to access mental health care.

a. Service Proximity to Population Residence

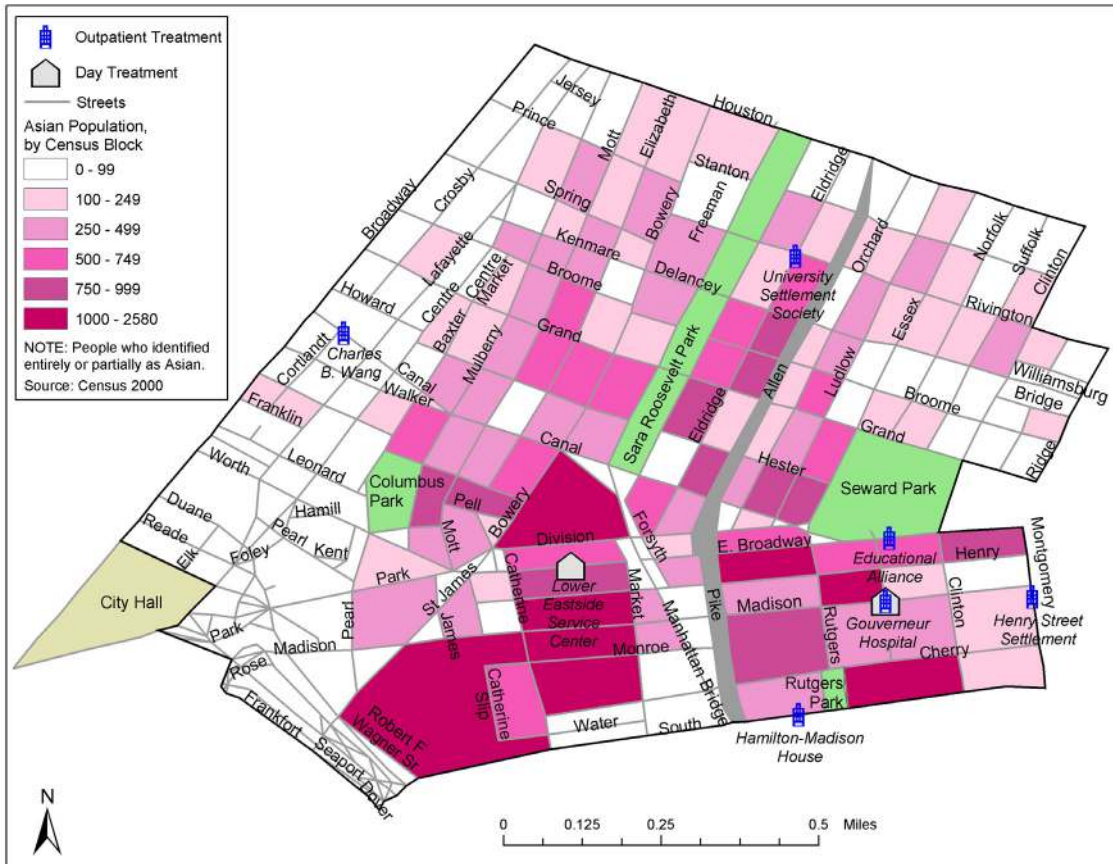
As shown in Figure 9, there are seven outpatient mental health facilities in the Chinatown area.

¹³¹ Universe: Asian Alone Population 25 years and over (39,246).

¹³² Limited English language proficiency can be defined as individuals who are classified by the Census as speaking English either "not well" or "not at all".

¹³³ To be classified as mentally disabled by the U.S. Census, individuals must have a mental or emotional condition that affects learning, remembering, or concentrating, lasts 6 months or more, and makes the performance of certain activities difficult.

Figure 9: Chinatown Area Mental Health Service Providers



Produced by the Asian American Federation of New York

These are:

Charles B. Wang Community Health Center (125 Walker Street)

Educational Alliance (197 East Broadway)

Gouverneur Hospital: 1) Asian Bicultural Clinic and 2) Center for Older Adults (227 Madison Street)

Hamilton-Madison House (253 South Street)

Henry Street Settlement Community Consultation Center (40 Montgomery Street)

Lower East Side Service Center (46 East Broadway)

University Settlement Society Victory Guild Consultation Center (184 Eldridge Street)

As evident in Figure 9, nearly all of Chinatown's mental health facilities are located south of Canal Street, which has a greater population density as compared to the region north of Canal Street.

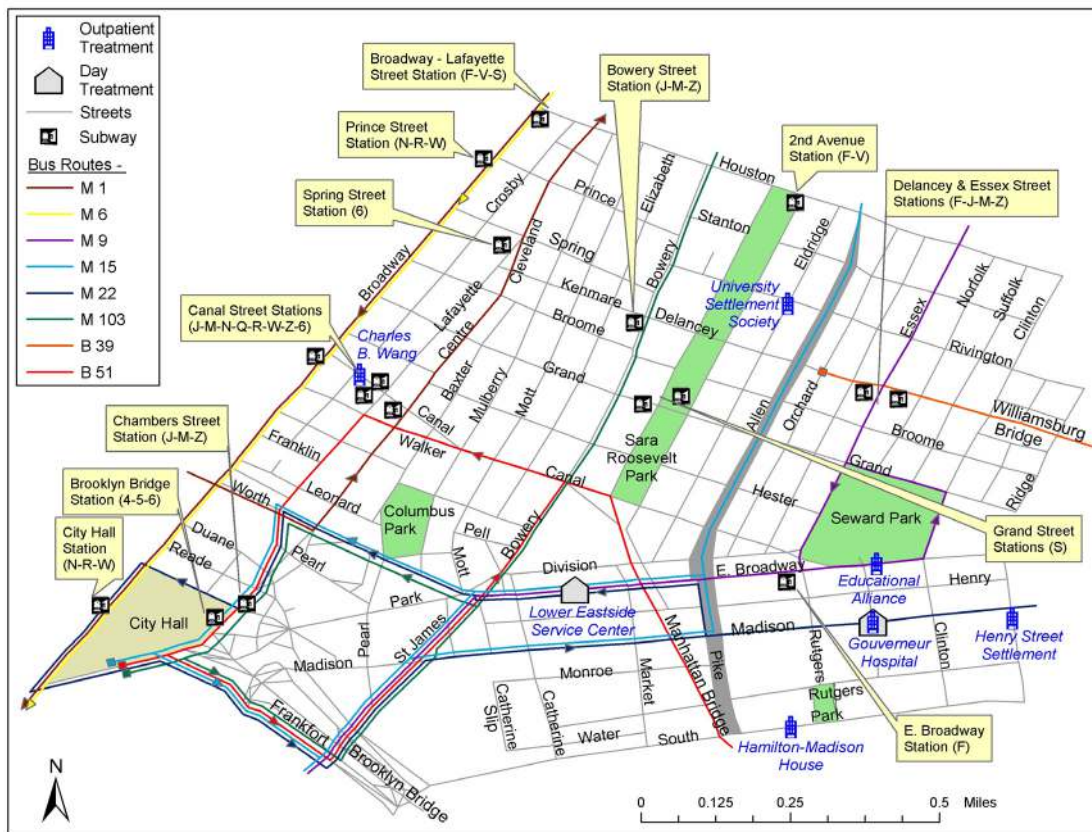
b. Transportation Access to Services

Five subway stations, Canal Street, East Broadway, Essex/Delancey, Bowery, and Grand Street stations service the central Chinatown area. The following trains make stops at these stations:

- Canal Street: 6, J, M, Z, N, R, Q, W
- East Broadway: F
- Essex/Delancey: J, M, Z, F
- Bowery: J, M, Z
- Grand (restricted access as of August 1, 2001 for repair): S

Several public bus routes also serve Chinatown, including the M1 (Broadway/Centre), M6 (Broadway/ Centre), M9 (East Broadway), M15 (Madison/East Broadway), M22 (Madison/East Broadway), and M103 (Bowery)¹³⁴.

Figure 10: Chinatown Area Mental Health Service Providers and Public Transportation



Produced by the Asian American Federation of New York

Chinatown's mental health facilities are quite accessible using public transportation. All locations are accessible by bus, and the majority of the facilities are accessible by both bus and subway.

- The Charles B. Wang Community Health Center is the most accessible using both forms of public transportation. It is located within walking distance (1/4 mile) to five bus lines (B51, M51, M15, M22 & M103) and the Canal Street Subway Stations, which service eight lines (N, R, 6, J, M, Z, Q & W).
- Educational Alliance, Gouverneur Hospital, and University Settlement Society are also accessible by both forms of public transportation. Educational Alliance and Gouverneur Hospital are within walking distance to three bus lines (M9, M15 & M22) and the East Broadway Subway Station, which services the F line. University Settlement Society is within walking distance to four bus lines (M9, M15, M103 & B39) and the Second Avenue Subway Station, which also services the F line.
- Hamilton-Madison House, Henry Street Settlement, and Lower Eastside Service Center are only accessible by bus. Lower Eastside Service Center is within walking distance to five bus lines (M9, M15, M22, M103 & B51). Hamilton-Madison House is within walking distance to three bus lines (M15, M22 & B51). Lastly, Henry Street Settlement is within walking distance to two bus lines (M9 & M22).

¹³⁴ The Grand Street Shuttle buses also are available in this neighborhood but do not appear in Figure 10. This route is not included on MTA's bus route map.

Because more than 60% of Chinatown workers live outside the study area, an important topic that should be explored further is the issue of Chinatown workers' accessibility to mental health services within their residential neighborhoods outside Manhattan's Chinatown.

Appendix E: Bibliography

American Red Cross in Greater New York. (2002). *Critical Needs in the Aftermath of September 11: Findings from Surveys: Two Months and Five Months Later*.

Applied Research and Consulting, LLC, Columbia University Mailman School of Public Health, New York State Psychiatric Institute. (2002, May 6). *Effects of the World Trade Center Attack on NYC Public School Students*. Initial Report to the New York City Board of Education.

Asian American Federation of New York. (April 2002). *Chinatown After September 11th: An Economic Impact Study*.

Asian American Federation of New York. (November 2002). *Chinatown One Year After September 11th: An Economic Impact Study*.

Asian Americans for Equality. (2002). *Wellness Project Reaches Out to Asian Communities Suffering From Post 9/11 Stress*.

Atkinson, D. R., Lowe, S. M., & Matthews, L. (1995). Asian-American acculturation, gender, and willingness to seek counseling. *Journal of Multicultural Counseling & Development*, 23, 130-138.

Belden Russonello & Stewart. (2002). *Children and Crisis: NYC's Response After 9/11*. A Report Prepared for Citizens' Committee for Children of New York.

Brislin, R. W. (1980). Translation and content analysis of oral and written materials. In H. Triandis & J. W. Berry (Eds.), *Handbook of cross-cultural psychology* (vol.2, pp.389-444). Boston: Allyn & Bacon.

Chen H., Chung, H., Chen, T., Fang, L., & Chen, J-P. (2002). *The Emotional Distress in a Community After the Terrorist Attack on the World Trade Center*. New York: Charles B. Wang Community Health Center.

Duenwald, M. (2002, October 29). "Coping with the Spiral of Stress that Layoffs Create." *New York Times*.

Ely, M., Anzul, M., Friedman, T., & Garner, D. (1991). *Doing qualitative research: Circles within circles*. London: The Falmer Press.

Galea, S., Ahern, J., Resnick, H., Kilpatrick, D., Bucuvalas, M., Gold, J., & Vlahov, D. (2002). Psychological Sequelae of the September 11 Terrorist Attacks in New York City. *New England Journal of Medicine*, 346(13):982-7.

Gim, R. H., Atkinson, D. R., & Whiteley, S. (1990). Asian-American acculturation, severity of concerns, and willingness to see a counselor. *Journal of Counseling Psychology*, 37, 281-285.

Inman, A. G., Constantine, M. G., & Ladany, N. (1999). Cultural value conflict: An examination of Asian Indian women's bicultural experience. In D. S. Sandhu (Ed.), *Asian and Pacific Islander Americans: Issues and Concerns for Counseling and Psychotherapy* (pp. 31-41). Commack, NY: Nova Science Publishers.

Lipton, E. (2002, April 19). "In Cold Numbers, a Census of the Sept. 11 Victims." *New York Times*.

Loo, C., Tong, B., & True, R. (1989). A bitter bean: Mental health status and attitudes in Chinatown. *Journal of Community Psychology*, 17, 284-296.

Mahrer, A. R. (1988). Discovery-oriented psychotherapy research: Rationale, Aims, and methods. *American Psychologist*, 43, 694-702.

Matsuoka, J. K., Breaux, C., & Ryujin, D. H. (1997). National utilization of mental health services by Asian Americans/Pacific Islanders. *Journal of Community Psychology*, 25, 141-145.

McKinsey & Co & United Services Group. (2002). *A Study of the Ongoing Needs of People Affected by the World Trade Center Disaster*.

Morrissey, M. (1997). The invisible minority: Counseling Asian Americans. *Counseling Today*, 40(6), 1, 21-22.

New York City Department of Health and Mental Hygiene. (March 2003). *Summary of Vital Statistics, 2001*.

New York City Department of Health and Mental Hygiene. (2001). *A Community Needs Assessment of Lower Manhattan Following the World Trade Center Attack*.

Okazaki, S. (1997). Sources of ethnic differences between Asian-American and White American college students on measures of depression and social anxiety. *Journal of Abnormal Psychology*, 106, 52-60.

O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology*, 17, 17-30.

Root, M. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy*, 22, 349-356.

Schlenger, W. E., Caddell, J. M., Ebert, L., Jordan, B. K., Rourke, K. M., Wilson, D., Thalji, L., Dennis, J. M., Fairbank, J. A., Kulka, R. A. (2002). Psychological Reactions to Terrorist Attacks: Findings From the National Study of Americans' Reactions to September 11. *Journal of the American Medical Association*, 288, 581-588

Solberg, V. S., Ritsma, S., Davis, B. J., Tata, S. P., & Jolly, (1994). Asian-American students' severity of problems and willingness to seek help from university counseling centers: Role of previous counseling experience, gender, and ethnicity. *Journal of Counseling Psychology*, 41, 275-279.

Sue, S. (2002). *Asian American mental health: What we know and what we don't know*. In W.J. Lonner, D.L. Dinnel, S.A. Haynes, & D.N. Sattler (Eds.) *Online Readings in Psychology and Culture* (Unit 3, Chapter 4), (<http://www.wvu.edu/~culture>), Center for Cross-Cultural Research, Western Washington University, Bellingham, Washington, USA.

Sue, S., Fujino, D.C., Hu, L-T., Takeuchi, D. T., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting & Clinical Psychology*, 59, 533-540.

Tracey, T. J., Leong, F. T., & Glidden, C. (1986). Help seeking and problem perception among Asian Americans. *Journal of Counseling Psychology*, 33, 331-336.

Tsai, M, Teng, L. N., & Sue, S. (1980). Mental status of Chinese in the United States. In A. Kleinman & T. Y. Lin (Eds.), *Normal and deviant behavior in Chinese culture*. Hingham, MA: Reidel.

United Way of New York City. (May 2002). *Slicing the Apple: Need Amidst Affluence in New York City*.

Urban Justice Center. (2002) *Ripple Effect: The Crisis in NYC's Low-Income Communities after September 11th*.

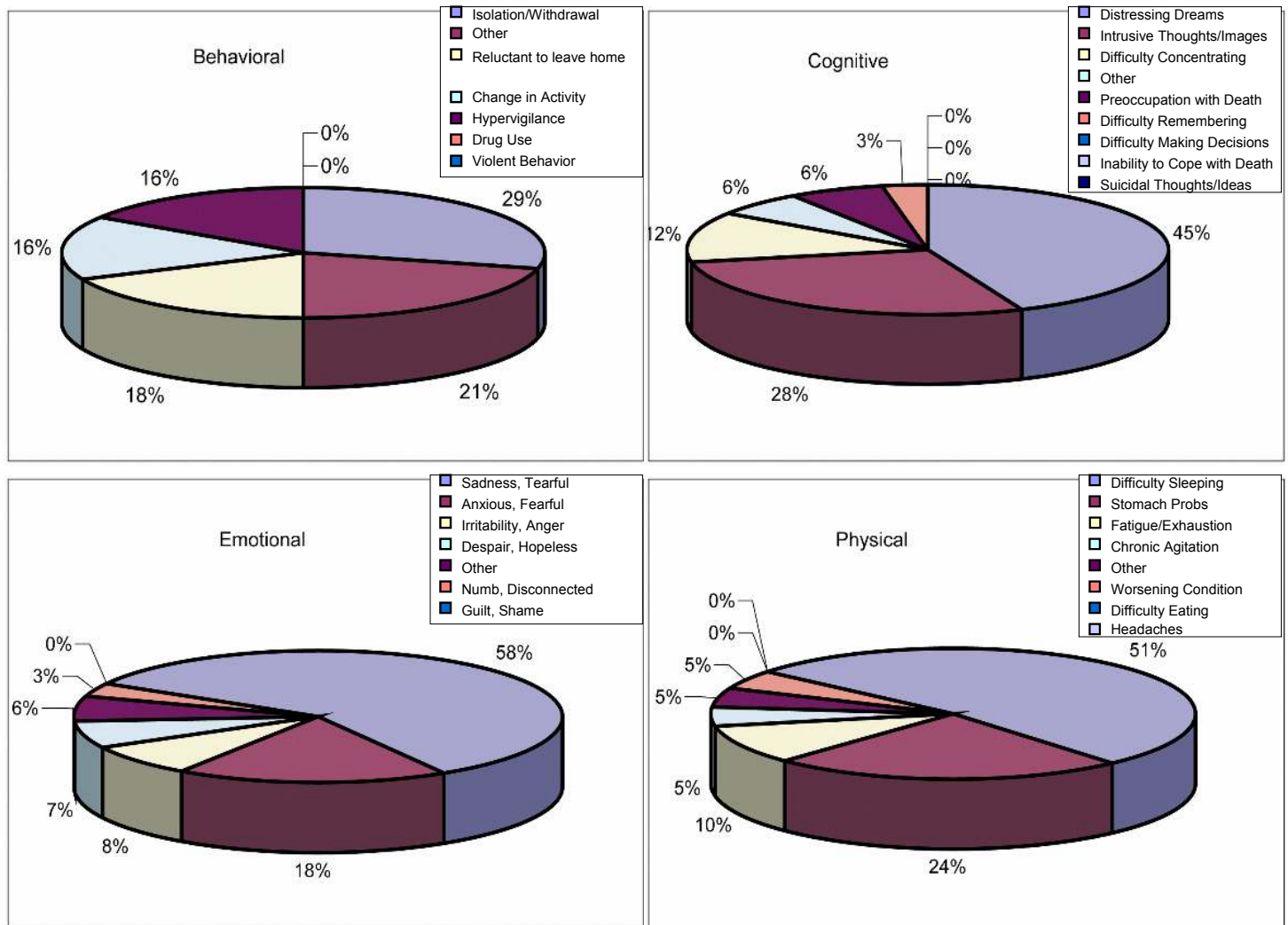
World Journal, (2002, September 17). "Chinese are Conservative in Seeking Mental Health Treatment."

Ying, Y-W. & Miller, L. S. (1992). Help-seeking behavior and attitude of Chinese Americans regarding psychological problems. *American Journal of Community Psychology*, 20, 549-556.

Zane, N., Hatanaka, H., Park, S. S., & Akutsu, P. (1994). Ethnic-specific mental health services: Evaluation of the parallel approach for Asian-American clients. *Journal of Community Psychology*, 22, 68-81.

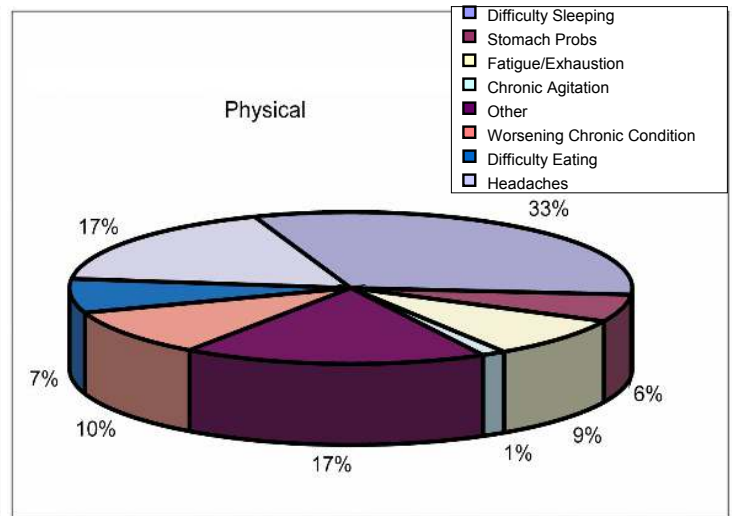
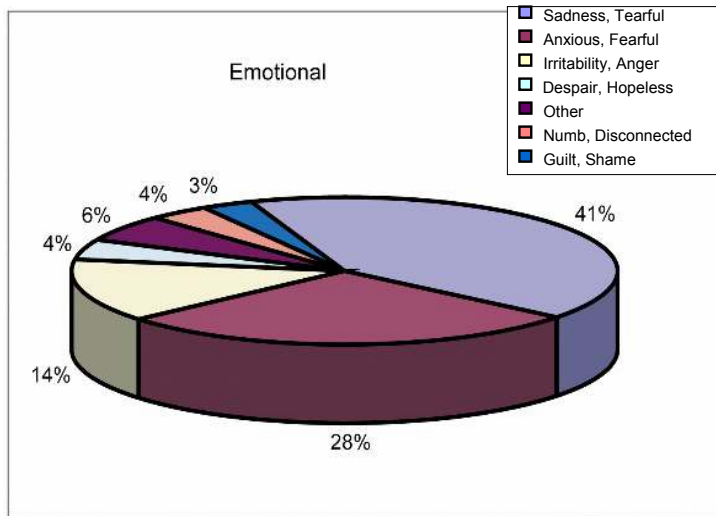
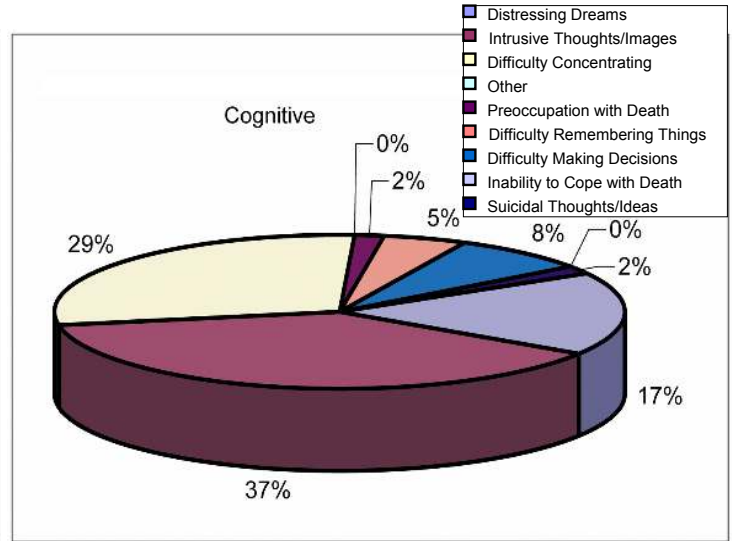
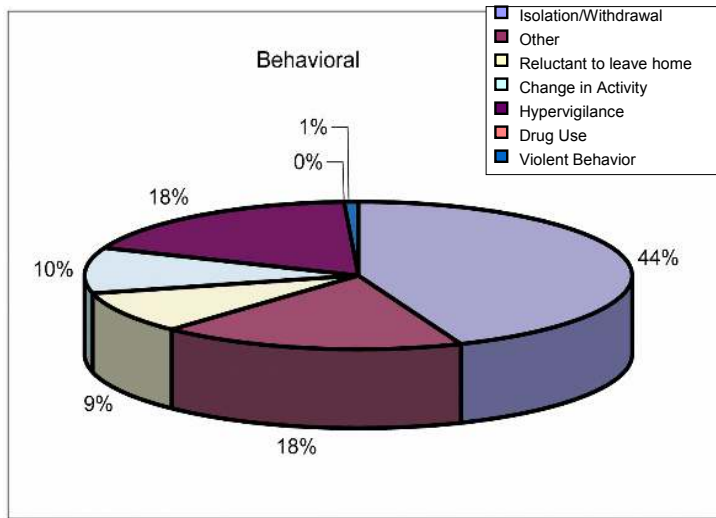
Appendix F: Project Liberty Expressed Event Reactions¹³⁵

Children (6-11)

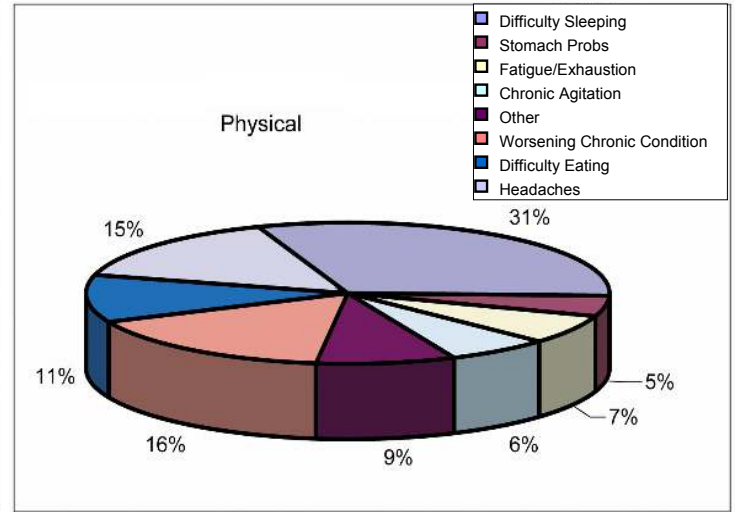
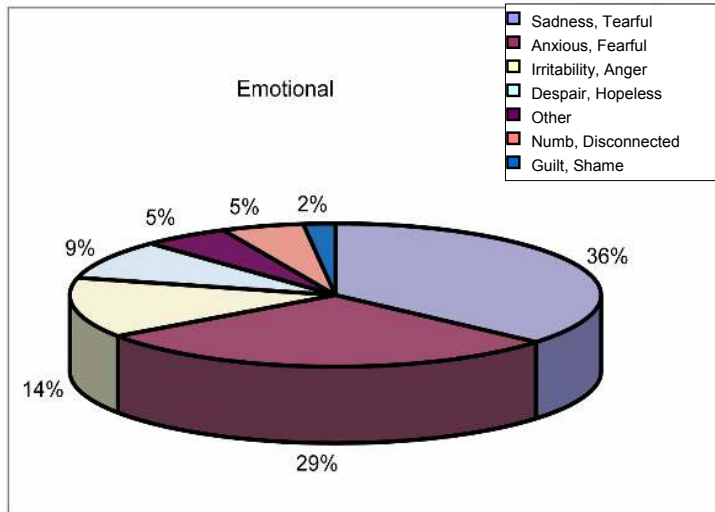
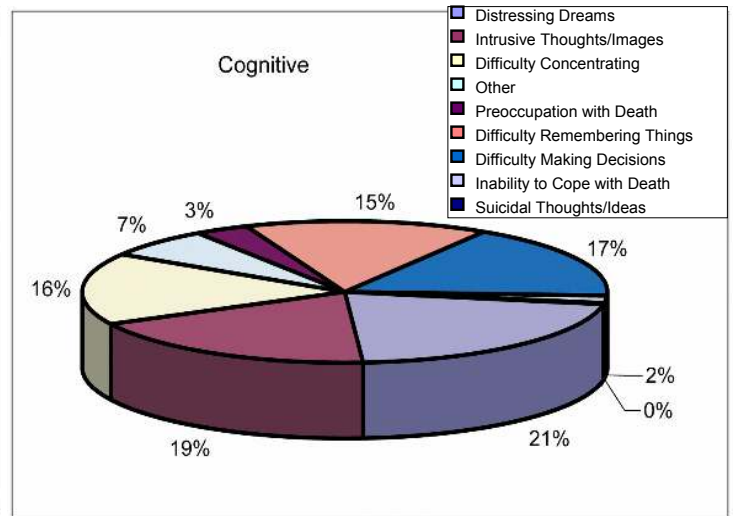
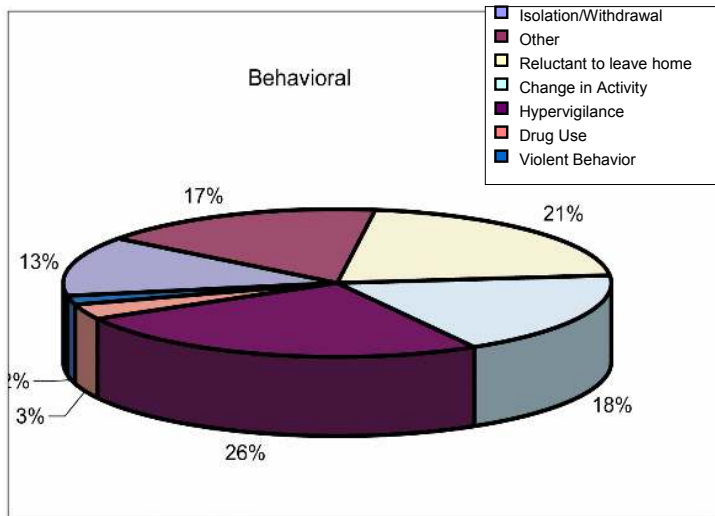


¹³⁵ Does not include "none" or "unknown."

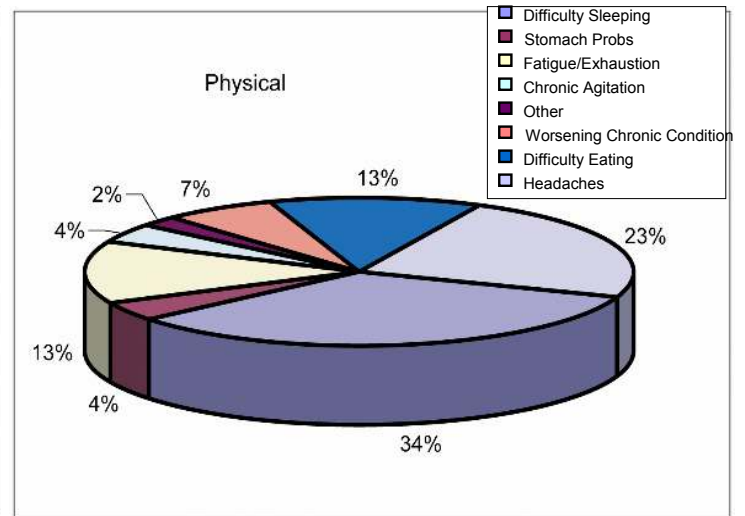
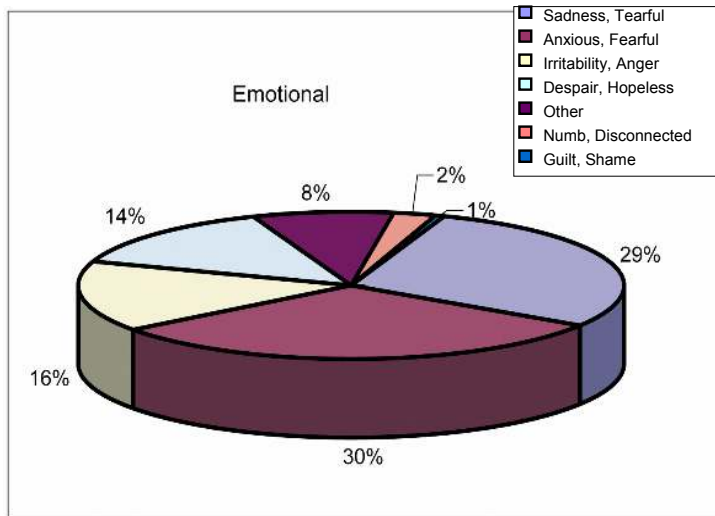
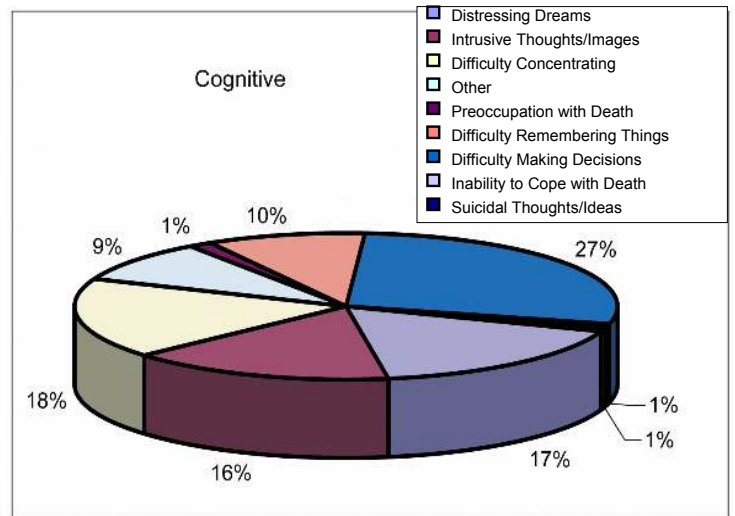
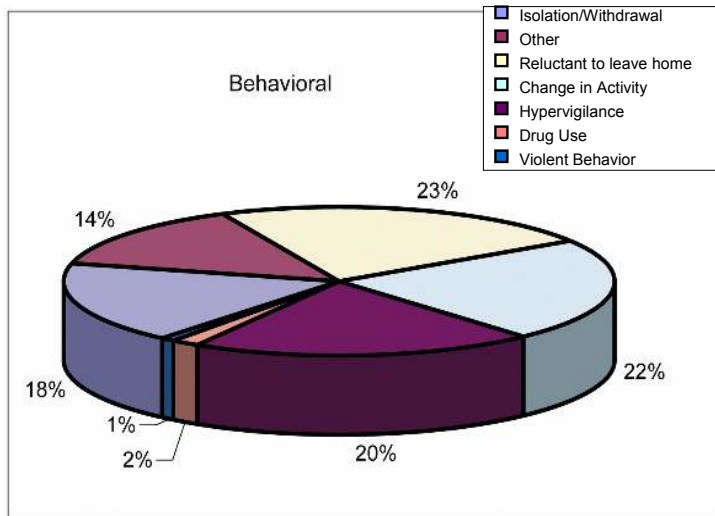
Adolescents (12-17)



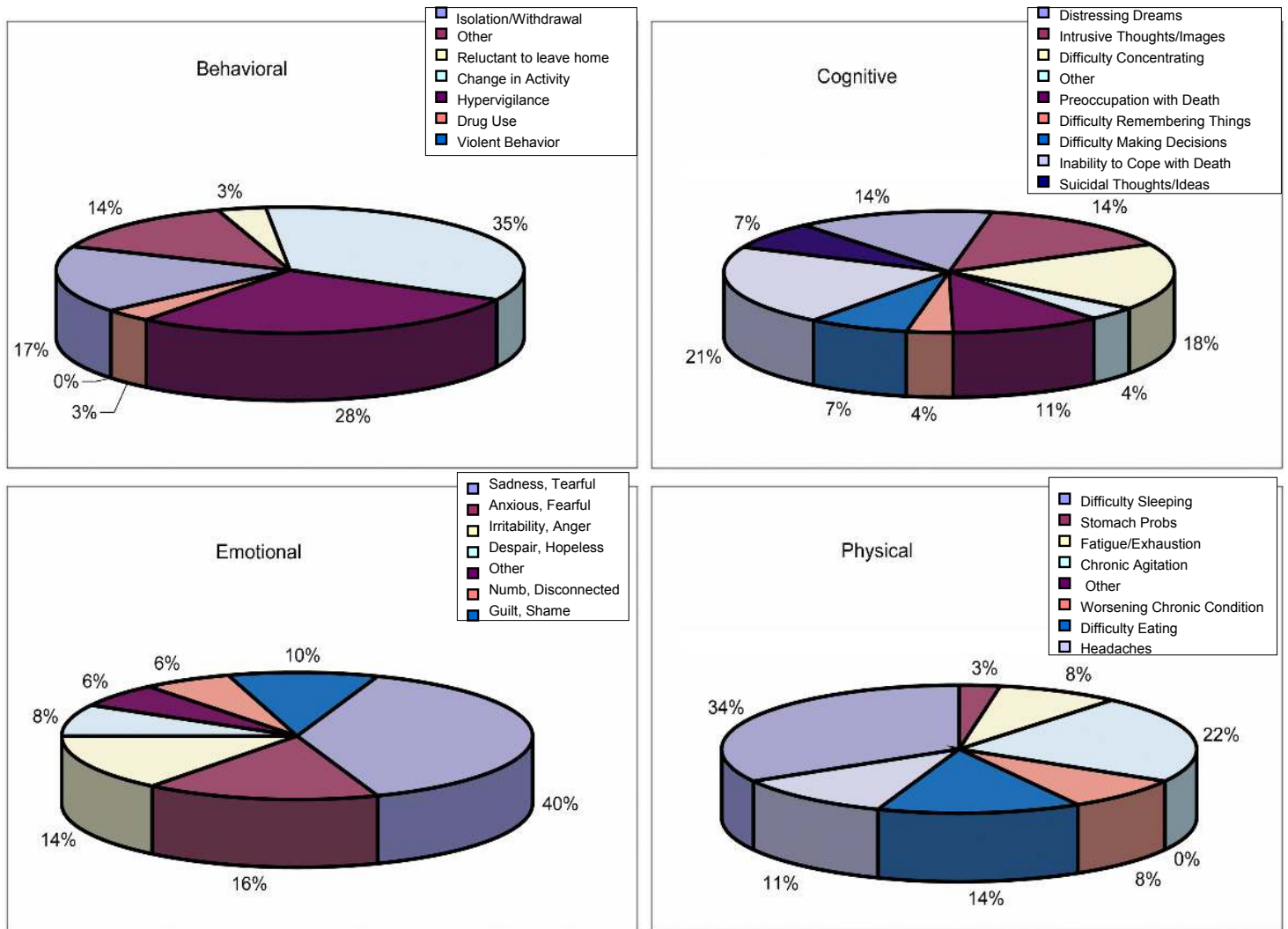
Older Adults (55+)



Displaced Workers (all ages)



Asian American Family Members of Missing/Deceased (all ages)



ACKNOWLEDGEMENTS

The Federation acknowledges the support of the following organizations, without which this study would not have been possible.

Funding support for this study has been generously provided by:

The Robert Wood Johnson Foundation

Quantitative data for this study have been supplied by:

Hamilton-Madison House/Project Liberty
American Red Cross
Mental Health Association/Asian LifeNet
Chinese Community Social Services and Health Council
New York City Health and Hospitals Corporation
Metropolitan Transportation Authority – New York City Transit Authority

Qualitative data for this study have been supplied or facilitated by:

Asian Americans for Equality
Asian American Legal Defense and Education Fund
Charles B. Wang Community Health Center
Chinese-American Planning Council
Chinatown Manpower Project
Chinatown YMCA
Chinese Christian Herald Crusades
City Hall Senior Center
Coalition for Asian American Children and Families
Community School District 2
Consulate General of India, New York
Consulate General of the People's Republic of Bangladesh, New York
D.R.U.M. (Desis Rising Up and Moving)
Filipino American Human Services, Inc.
General Consulate of Pakistan in New York
Gouverneur Hospital – Asian Bicultural Clinic
Hamilton-Madison House
Henry Street Settlement
International Institute of New Jersey
Japanese American Social Services, Inc.
Knickerbocker Village Senior Center
Lower Eastside Service Center
Lutheran Family and Community Services – New Life Center
Nav Nirmaan Foundation
New York Asian Women's Center
New York Academy of Medicine
New York City Health and Hospitals Corporation
Project Open Door Senior Center
Project Phoenix
Pragati, Inc.
Queens Child Guidance Center
Saint Vincent Catholic Medical Center
South Asian Council for Social Services
Tzu-Chi Buddhist Foundation
United Way of New Jersey of Middlesex County
University Settlement
Urban Justice Center

The Asian American Federation of New York is also grateful to the following individuals who have offered invaluable advice, insights, information, and assistance:

Laura Abbott	Laura M. Abbott Communications
Sudha Acharya	South Asian Council for Social Services
Lorraine Ahto	Henry St. Settlement
Shazia Akram	Asian American Federation of New York
Mariam Aziz	New York Asian Women's Center
Robert Bender	American Red Cross
Ravi Bhasin	Queens Child Guidance Center
Sebastian Bonner	New York Academy of Medicine
Ray Brescia	Urban Justice Center
Renee Burawski	Project Phoenix
Rosa Casiello-O'Day	P.S. 42
Julie Chan	Asian American Federation of New York
Kathleen Chan	
Manna Chan	Lower Eastside Service Center, Inc.
Noreen Chan	Asian American Federation of New York
Sarah Chan	Charles B. Wang Community Health Center
Susan Chan	Asian Americans for Equality
Jen-Mai Chang	
Ying-Ling Chao	Gouverneur Hospital
David Chen	Chinese-American Planning Council
Diana Chen	Gouverneur Hospital - Asian Bicultural Clinic
Hong-Tu Chen	Charles B. Wang Community Health Center
Lee Chen	Asian LifeNet
May Chen	UNITE, Local 23-25
Jeffrey Chen	Chinese-American Planning Council
Pauline Chen	Chinese-American Planning Council
Tien Chen	Asian LifeNet
A. Cheng	Gouverneur Hospital
Isabel Ching	Hamilton-Madison House
Patty Chiu	Asian American Federation of New York
Chris Cho	Chinese Community Social Service and Health Council; Bellevue Hospital
Yu-Wen Chou	Gouverneur Hospital
Roopa Choudhury	New York Asian Women's Center
Jennifer Chu	International Institute of New Jersey
Toby Chua	Adventures in Teaching and Counseling
Mary Courtney	New York University's Child Study Center
Del Carmen Cuthbeart	University Settlement
Cynthia Dames	
Angela DeCastro	Bellevue Hospital
Mala Desai	Pragati
Agnelo Dias	Queens Child Guidance Center
Dionne Dougall	Burness Communications
John Draper	Mental Health Association/LifeNet
Jeanne Eng	Asian American Federation of New York
Lin Fang	Charles B. Wang Community Health Center
Amanda Franks	Burness Communications
Sandro Galea	New York Academy of Medicine
Dia Ganguly	Asian American Federation of New York
Ramon Gil	Ramon Gil Art & Design
Jack Guo	Volunteer
Anita Gundanna	Coalition for Asian American Children and Families
Adam Gurvitch	New York Immigration Coalition
Elaine Ho	Gouverneur Hospital
Katy Ho	Consultant
Kit Ho	Hamilton-Madison House
Kristin Hokoyama	Asian American Federation of New York
Natalie Hon	Asian American Federation of New York
Huai-Chun Hsu	
Renata Huang	Independent Documentarian
Yingsi Huang	Chinatown Manpower Project

Eun Jin Ji	Columbia University
Yung Jing	Hamilton-Madison House
Marian Tan Johnson	Coalition for Asian-American Children and Families
Theresa Jung	Charles B. Wang Community Health Center
Parag Khandhar	Asian American Federation of New York
Paul Kim	
Lori Kitazono	Asian American Federation of New York
James Knickman	The Robert Wood Johnson Foundation
Michelle Ko	Asian American Federation of New York
Michael Kuo	Municipal Arts Society
Charlie Lai	Asian American Federation of New York
Margaret Lai	Lower East Side Service Center
Bill Lam	Transcendent International, LLC
Kenneth Lam	Chinese Christian Herald Crusades
Linda Lantieri	Educators for Social Responsibility
Joana Law	Elmhurst Hospital Center
Maggie Lau	Asian American Federation of New York
Vincent Lau	
Catherine Lee	Chinese-American Planning Council
Deborah Lee	Hamilton-Madison House
Hong Shing Lee	Chinatown YMCA
Jessica Lee	Coalition for Asian American Children and Families
JoAnn Lee	Asian American Federation of New York
Wendy Lee	Volunteer
Jacky Leung	Columbia University
Vanessa Leung	Coalition for Asian American Children and Families
Karly Li	
Winnie Li	Asian American Federation of New York
Solan Liang	Hamilton-Madison House
Jean Lim	The Robert Wood Johnson Foundation
Naomi Lim	Asian American Federation of New York
Pei-Ying Lin	Columbia University
Karen Liu	Chinese-American Planning Council
William Liu	Tzu-Chi Buddhist Foundation
Ken Lo	New York City Department of Health
Yuen Ling Lo	Gouverneur Hospital
Chi Loek	Chinese-American Planning Council
Nelson Louis	Gracie Square Hospital
Erica Lowry	American Red Cross
Holly Lung	Chinese-American Planning Council
Tracy Luo	Mental Health Association/Asian LifeNet
Pei-Wen Ma	Columbia University
Winnie Ma	Hamilton-Madison House
Michelle Mai	Chinatown YMCA
Karen Manassee	Safe Horizon
Trish Marsik	Project Liberty, New York City
Hisano Matsuzawa	Japanese American Social Services, Inc
Pam McKeown	Oklahoma Department of Mental Health and Substance Abuse Services
Pamela Mei	P.S.124
Frank T. Modica	Hamilton-Madison House
Gingy Moy	P.S.2
Yu Soung Mun	Young Korean-American Service & Education Center, Inc.
Po-Ling Ng	Chinese-American Planning Council
Tommy Ng	
Tao Nguyen	Hamilton-Madison House
Setsuko Matsunaga Nishi	Asian American Federation of New York
Kay Nishiyama	Asian American Federation of New York
Tuhina De O'Connor	New York Asian Women's Center
Daniel Oh	Volunteer
Sherry Lynn Peralta	Filipino American Human Services, Inc.
Mel Pinoi	New York Health and Hospitals Corporation
Chun Poon	Mental Health Association/Asian LifeNet
Kiran Prasad	Asian American Federation of New York
Dwayne Proctor	The Robert Wood Johnson Foundation

Aruna Rao	South Asian Mental Health Awareness in Jersey
Ophelia Reyes	Filipino American Human Services Inc.
Jennifer Rhee	Asian American Federation of New York
David Ries	Volunteer
Carmen Rivera	University Settlement
Marjorie Robbins	Community School District 2
Benjamin Ross	New York Immigration Coalition
Karen Roth	New York Health and Hospitals Corporation
Alex Saingchin	Asian American Federation of New York
Mari Sakaji	Japanese American Social Services, Inc.
Rosalie Sanchez	Asian American Federation of New York
Janine Scafaria	Seton Hall University
Carol Schadelbauer	Burness Communications
Chun Sha	Chinatown Manpower Project
Girish Shah	Nav Nirmaan Foundation, Inc.
Mehula Shah	New York Asian Women's Center
Leon Shao	Gouverneur Hospital
Deborah Sheldon	American Red Cross
Debra Shime	Safe Horizon
Peter Shon	Columbia University
Vicki Shu	Asian American Federation of New York
Sonia Singhal	Columbia University
Yvonne So	Volunteer
Moona Syed	Pragati
Don Thoms	St. Vincent's Medical Center
Eugene Tomkiel	Educational Alliance
Michelle Tong	Asian American Federation of New York
Mabel Tso	Asian American Legal Defense and Education Fund
Nam Vo	Hunter College School of Social Work
Joyce Wale	New York Health and Hospitals Corporation
Anastasha Wang	Hamilton-Madison House
Nora Wang	Professional Network Group
Wendy Wang	Lutheran Family and Community Services – New Life Center
Robert Weber	Asian Americans for Equality
Kurt Weirich	American Red Cross
Susan Wilson	Garment Industry Development Corporation
Gail Wolsk	Project Liberty, New York City
Lisa Wong	Chinatown YMCA
Maggie Wong	Charles B. Wang Community Health Center
Theresa Wong	Charles B. Wang Community Health Center
Yuen Fan Wong	Gouverneur Hospital
Jacqueline Woo	Asian American Federation of New York
Jenny Wu	Hamilton-Madison House
Henry Ye	Lutheran Family and Community Services - New Life Center
Lillian Yeh	
Steve Yip	Chinese-American Planning Council
Alice Young	M.S.131
Debbie Zaslo	P.S.130
Michael Zisser	University Settlement
Shu Fen Zhao	

About the Asian American Federation of New York

Founded in 1989, the Asian American Federation of New York (the “Federation”) is a not-for-profit organization that provides public policy and community service leadership to identify and meet the critical needs of Asian Americans in the New York metropolitan area. The Federation serves the entire Asian American community by analyzing issues and voicing common concerns, advocating for beneficial policies, offering financial and management assistance, coordinating service delivery, and creating and heading unified, community-wide initiatives. The Federation has a membership of 35 community agencies that provide health and human services to diverse populations.

Working toward an empowered Asian American community with full participation in the larger society, the Federation is guided by the following priorities:

- Articulating Asian American concerns on public policy matters, and promoting understanding and cooperation between communities.
- Strengthening the capacity of community institutions.
- Generating human and financial resources for enhanced effectiveness in meeting community needs and aspirations.

The Federation’s public policy and research work focuses on issues related to resource allocation, community needs, service availability and accessibility, immigrant rights, and community development.

Since September 2001, the Federation has been engaged in a comprehensive *September 11th Relief, Recovery, and Rebuilding Initiative* that it spearheaded to address Asian American community needs resulting from the September 11th attacks. Part of this effort was the production of two landmark research reports, entitled *Chinatown After September 11th: An Economic Impact Study* and *Chinatown One Year After September 11th: An Economic Impact Study*. These reports documented an unprecedented level of economic disruption in Chinatown post-September 11th and set forth a number of policy recommendations to enable government, funders, and other stakeholders to more adequately address the community’s economic recovery needs. In addition, the Federation’s efforts have included establishing a community service center in Chinatown, coordinating outreach and relief services, providing financial aid through the *Asian American Federation WTC Fund*, and serving as a founding member of the 9/11 United Services Group, a 13-member city-wide consortium formed to coordinate and provide assistance to people affected by the September 11th tragedy. In November 2002, the Federation also launched an expansive second phase of the initiative in conjunction with five partner agencies from various Asian communities to focus upon the ongoing and unmet needs of Asian American families resulting from the September 11th tragedy.

Among other pivotal leadership functions, the Federation is one of the three Asian American organizations on the East Coast selected by the U.S. Census Bureau to operate a Census Information Center. The center was established in August 2001 to conduct data and policy analysis and to encourage representation of the Asian American community in Census Bureau censuses and surveys. The Census Bureau’s designation recognized the Federation’s success in leading the Asian American Task Force on Census 2000, a coalition of 65 organizations that advised the Census Bureau and ensured an accurate count of Asian Americans in Census 2000.

Other current Federation projects, in addition to extensive support of its member agencies, include the New Heritage of Giving, an initiative to promote philanthropy, civic involvement, and volunteerism among Asian Americans.

For more information on the Federation, visit www.aafny.org or call 212-344-5878.

ASIAN AMERICAN FEDERATION BOARD OF DIRECTORS

Dr. Yung Duk Kim, Chairperson
Executive Advisor, Hyundai Corporation (USA)

Mr. Jeffrey Chin, Vice Chairperson
Partner, Ernst & Young, LLP

Mr. Dong Suk Suh, Treasurer
President & CEO, D.S. Starr

Muzaffar Chishti, Esq., Secretary
Senior Policy Analyst, Migration Policy Institute

Ms. Mary Rothwell Davis
Principal Court Attorney, Integrated Domestic Violence Court for Bronx County

Ms. Susan C. Dessel
Artist

Mr. Paul D.C. Huang
President, C.J. Huang Foundation

Peter D. Lederer, Esq.
Attorney-at-Law

Howard H. Li
Chairman & CEO, Waitex International Company

Dr. Jean Raymundo Lobell
Senior Consultant, Community Resource Exchange

Sylvester Mendoza, Jr., Esq.
Director, Diversity Strategies, Quest Diagnostics

Gary S. Moriwaki, Esq.
Partner, Young Moriwaki Isaacs & Greenfader, LLP

Dr. Setsuko Matsunaga Nishi
Professor Emeritus, City University of New York

Ms. Grace Lyu Volckhausen
Commissioner, New York City Commission on Human Rights

HONORARY BOARD

U.S. Senator Daniel K. Inouye
Ms. Midori Shimanouchi Lederer
Loida Nicolas Lewis, Esq.
Francis Y. Sogi, Esq.
Oscar L. Tang
Procopio U. Yanong, MD