

### Alcohol Use in Polish 9/11 Responders: Implications for Cross-Cultural Treatment

CRAIG L. KATZ, MD  
DIDIER JUTRAS-ASWAD, MD  
MARTA KILIMAN, LMSW  
IWONA PILATOWICZ, CSW  
EVARISTO AKERELE, MD  
KATHRYN MARRONE, LCSW  
FATIH OZBAY, MD

More than 35,000 individuals are estimated to have responded to the World Trade Center (WTC) site following the terrorist attacks of September 11, 2001. The federally funded WTC Medical Monitoring and Treatment Program (WTCMMTP) provides medical monitoring and occupational medicine treatment as well as counseling regarding entitlements and benefits to the workers and volunteers who participated in the WTC response. A major component of the WTCMMTP is the WTC Mental Health Program (WTCMHP), which offers annual mental health assessments and ongoing treatment for those found to have 9/11 associated mental health problems. In the program's 9.5 years of evaluating and treating mental health problems in thousands of Ground Zero responders, diversity in multiple domains (e.g., gender, family, profession and employment status, state of physical health, cultural identity, and immigration status) has been a hallmark of the population served by the program. To illustrate the types of issues that arise in treating this diverse patient population, the authors first present a representative case involving a Polish asbestos worker with an alcohol use disorder. They then discuss how accepted alcohol treatment modalities can and often must be modified in providing psychiatric treatment to Polish responders, in particular, and to foreign-born patients in general. Treatment modalities discussed include cognitive and behavioral therapy, relapse prevention strategies, psychodynamic therapy, motivational approaches, family therapy, group peer support, and pharmacotherapy. Implications for the practice of addiction psychiatry, cultural psychiatry, and disaster psychiatry are discussed. (*Journal of Psychiatric Practice* 2012;18:55-63)

**KEY WORDS:** September 11, 2001, disaster psychiatry, addiction, alcohol dependence, cultural psychiatry

#### BACKGROUND

More than 35,000 individuals are estimated to have responded to the World Trade Center (WTC) site following the terrorist attacks of September 11, 2001.<sup>1</sup> The federally funded WTC Mental Health Program (WTCMHP) offers mental health monitoring examinations and treatment for workers and volunteers who participated in the WTC response. The WTCMHP involves two components: 1) it offers annual mental health assessments and 2) it provides ongoing treatment for those found to have 9/11 associated mental health problems. The WTCMHP is part of the larger WTC Medical Monitoring and Treatment Program (WTCMMTP) which provides medical monitoring and occupational medicine treatment as well as counseling regarding entitlements and benefits. In the program's 9.5 years of evaluating and treating 9/11 associated mental health problems in thousands of Ground Zero (GZ) responders, diverse backgrounds and needs have been a hallmark of the population served by the program.<sup>2</sup>

Because disasters strike across countries, cultures, and all levels of society,<sup>3</sup> they can be thought of as great levelers that affect a cross-section of the populace. Patients of the WTCMHP, despite their common link of having worked as responders at GZ or associated sites, differ from one another on many other

---

KATZ, KILIMAN, PILATOWICZ, AKERELE, MARRONE, and OZBAY: Mount Sinai School of Medicine, New York; JUTRAS-ASWAD: Mount Sinai School of Medicine and Université de Montréal.

Copyright ©2012 Lippincott Williams & Wilkins Inc.

Please send correspondence to: Craig L. Katz, MD, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1257, New York, NY 10029. craig.katz@mssm.edu

This work was supported by the Centers for Disease Control and Prevention, National Institute of Occupational Safety and Health (contract 200-2002-0038 and grant 5U1O 0H008232), the American Red Cross Liberty Fund, The September 11th Recovery Program, The Bear Stearns Charitable Foundation, The September 11th Fund, The Robin Hood Foundation Relief Fund and many others.

DOI: 10.1097/01.pra.0000410989.46346.14

## Practitioner's Corner

dimensions, including gender; family; profession and employment status; state of their physical health; cultural identity; and immigration status. A range of ethnic groups has been treated in the WTCMHP. The majority of the foreign-born workers at GZ were from Latin America (predominantly Ecuador and Colombia) or Eastern Europe (predominantly Poland). Research concerning the medical treatment arm of the WTCMMTP found that Polish patients comprised 17.6% of individuals served by the program.<sup>4</sup> In 2010, 957 patients received mental health treatment in the WTCMHP, of whom 126 (13%) were Polish patients who were cared for by three Polish speaking clinicians. Of the 348 intakes of new mental health patients in this same period, 62 were Polish. The substantial number of Polish patients underscores the important role of cultural considerations in the mental health treatment provided by the WTCMHP. In this article, we focus on these patients to exemplify the types of cross-cultural considerations that arise in the WTCMHP.

Asbestos workers were a largely unheralded segment of the WTC responder population who were extensively involved in the clean-up efforts. Many of these workers were Polish. Accumulated clinical experience points toward the pervasiveness of alcohol use in this group relative to many of the other ethnic groups in the program, as well as the distinct challenges involved in engaging and treating these patients for their drinking problems. To illustrate these issues, we first present a representative case involving a Polish asbestos worker with an alcohol use disorder and then discuss how accepted alcohol treatment modalities can and often must be modified in providing psychiatric treatment to Polish responders, in particular, and to foreign-born patients in general. Implications for the practice of addiction psychiatry, cultural psychiatry, and disaster psychiatry are discussed.

### CASE REPORT

The patient was a 58-year-old monolingual Polish male employed at GZ as an asbestos handler from September 14, 2001 until the end of the clean-up operations in June 2002, working 7 days/week, predominantly in 12-hour night shifts. Despite his physical exhaustion, the patient was unable to fall asleep after his night shifts. He was troubled by distressing images of and thoughts about GZ and would awaken

amid frightening nightmares of GZ, often getting as few as 2–3 hours of sleep between shifts. In the context of his long-term employer's contractual commitment to GZ and with few employment opportunities elsewhere due to language and other barriers, the patient was determined to keep his job at GZ. Having lived in NY for many years, he also felt motivated to participate in the effort to respond to the 9/11 tragedy.

The patient described himself as a moderate drinker who, soon after 9/11, started reaching for alcohol to "loosen up, switch off" and get some sleep so that he would be able to work. By the time he finished his work at GZ in June 2002, he was drinking up to a 1/2 liter of vodka daily. The patient's sleep problems and daily alcohol use continued in subsequent years. He also became very irritable and angry. After an incident in which he stopped himself short from lashing out at someone at a train station, the patient became worried about the possible consequences of losing his temper at work or elsewhere. He first attended the WTCMMTP's screening program in 2008 after the decreasing availability of asbestos work allowed him time to come in to be evaluated for shortness of breath and tiring easily. During his mental health screening, the patient denied having any problems and refused treatment despite indicators of posttraumatic stress disorder (PTSD), clinical depression, and alcohol abuse. He attributed his difficulties to fatigue and stress. Because he had been able to maintain several periods of abstinence of a month or two in duration in the past, he also believed he was in control of his drinking.

The patient entered treatment after his second monitoring visit in 2010. At that time, he was planning to return to his family in Poland in the near future and was worried about the results of recent blood tests that had indicated some medical problems likely to be related to alcohol use, including elevated liver enzymes. He had been sober for 10 days and was asking for help to stay sober. The patient was offered intensive psychotherapeutic treatment three times/week focusing on rapidly engaging him in mental health treatment given that he was in the early stages of sobriety.

Married with a wife and three adult children in Poland, the patient came to the United States in the mid-1980s with the intention of staying for several years to earn enough money to ensure financial security for his family in Poland or, in time, to have them join him in the United States. He had worked as an

asbestos handler since his arrival. In his initial evaluation, the patient described a range of symptoms of anxiety and depression, which, along with his drinking and anger, he felt were signs of weakness that he needed to master on his own. He was interested in medication to help with cravings but declined a referral to a psychiatrist in the WTCMHP, opting instead to continue to receive medications from his Polish physician.

The patient responded well to psychoeducation about alcohol abuse and dependence and the relationship between alcohol abuse and mental health. Psychoeducational efforts were supported by giving the patient copies of relevant material from Polish textbooks<sup>5,6</sup> and Polish websites.<sup>7,8</sup> Initially motivated by fear about his abnormal medical tests and his plans of returning to Poland, he was further encouraged by the reduction of his troubling symptoms of anxiety and depression during the subsequent weeks of abstinence. Careful exploration over many sessions of his drinking history and patterns, the costs and benefits of drinking, and his triggers and denial mechanisms allowed the patient to acknowledge the risks inherent in his original treatment goal of controlled drinking after his return to Poland. He was then able to engage in developing relapse prevention strategies. In sobriety, the patient was able to begin to identify and explore his fears and anxieties about returning to his family and town after more than 20 years of separation. He also started to speak about the impact of his exposure to GZ and how he believed the sociopolitical and economic changes following 9/11 had affected his life.

### DISCUSSION

As illustrated by the case described above, targeted discussions have suggested that the foreign-born populations served by the WTCMHP have a multiplicity of distinct needs.<sup>9</sup> In the WTCMHP, the Polish WTC responders, such as the patient in the case described above, are predominantly male, middle-aged, and nearing retirement (a profile that is not unlike that of other foreign-born WTC responder populations). Many of the Polish workers had unclear immigration status while working at GZ and thereafter. The Polish group consisted of people from varied occupational backgrounds, including construction workers, farmers, lawyers, and doctors. They were principally involved in the clean-up effort and asbestos removal

from the buildings surrounding GZ. As in the case we described, work at GZ required long hours in difficult conditions, and workers were exposed to highly distressing levels of death and destruction, including bodies and body parts.

Our clinical experience suggests that Polish and other foreign-born patients may find drinking alcohol a culturally accepted way of dealing with distress or "taking the edge off." Many of our patients, such as the one described here, reported drinking alcohol to deal with painful emotions and memories related to their work at GZ, as well as drinking to "unwind" so that they could go to sleep. Many of the foreign-born workers at GZ had left their families in Poland and elsewhere, such as Central and South America, and had come to the United States seeking economic opportunities to improve the quality of life for their families back home. As a result, working friends were likely to become the main emotional support for many of these individuals, which could lead to feelings of pressure to "fit in" in order to keep their job by participating in social gatherings that often included alcohol.

As was the case with the patient described here, Polish culture normally does not condone seeking mental health treatment when experiencing distress.<sup>10</sup> In general, Polish individuals are far more likely to manifest emotions through physical symptoms or to suppress them completely, rather than naming the experienced feelings or even experiencing the feelings.<sup>11</sup> Thus, Polish individuals who are distressed may often complain of headaches, chest pain, trouble breathing, or stomach aches. As illustrated in the case we described, the patient's discussion with the doctor about his or her medical problems can therefore offer an opportunity to link the patient with mental health services. At the same time, medical concerns can be used as a motivating factor to continue to engage patients once they are in mental health treatment.

In addition, most benefits, such as social security disability payments and food stamps, are not available for Polish and other foreign-born WTC responders due to their unclear immigration status. Most of these individuals also do not speak English, creating a barrier in accessing medical care, legal advice, financial assistance, or even social circles outside of work. Therefore, it requires clinical creativity for mental health clinicians to build rapport with potential Polish patients and to assess and address their fundamental areas of need. If psychosocial stressors

## Practitioner's Corner

are not addressed, alcohol use and other mental health problems are likely to remain entrenched despite traditional psychiatric treatment approaches.

Another immediate obstacle to mental health treatment is this group's limited awareness and knowledge about mental health. Psychoeducation is a key factor in the beginning of every treatment. As with the patient we described, this includes a discussion of how people may resort to substance use in the context of PTSD and other post-traumatic sequelae in order to wrestle with the feelings of "losing one's mind" or "having a nervous breakdown." Like many other patients treated in the WTCMHP, the patient in the case we described expressed relief in response to normalization of his symptoms. This included challenging beliefs about mental health, masculinity, and alcohol use that are prevalent among Polish patients being treated in the WTCMHP.

The use of Polish reading material and resources, including Polish internet sites,<sup>7,8</sup> helps make this type of information more accessible to patients. As in the case described here, helping the patient become familiar with an accessible source of information and self-help material also played a crucial role in preparing the patient to return to a small town in Poland with limited access to mental health services and considerable stigma associated with using such services.

Once the ground work has been laid (i.e., by establishing initial rapport, identifying and targeting fundamental needs, and building basic mental health awareness), the clinician can start utilizing different modalities of treatment to help the patient.

### Cognitive Therapy

Originally developed for the treatment of anxiety and depression, cognitive therapy (CT) is now also widely used as a treatment for alcohol use disorders. This use is based on the premise that inadequate behaviors and coping mechanisms originate from emotions that themselves come from automatic thoughts or incorrect assumptions emerging from everyday life events. For example, a dependent individual who uses alcohol to self-treat social anxiety may see this substance as the only way to deal with misperceived social cues based on a false belief that his anxiety symptoms can be seen by everyone and will lead to rejection.

Cognitive therapy aims to identify, gently confront, and amend such erroneous beliefs of various kinds

that lead to substance use and make way for more appropriate thoughts. This manual-based, structured therapy requires the therapist to be active and the patient to work at home on exercises and tasks planned during sessions. This intensive approach usually necessitates 12–20 individual sessions. It can also be used as a group approach, in which the participants' experiences and feedback can be used by others as a learning experience. CT has been demonstrated to be effective for the treatment of alcohol dependence in several studies.<sup>12</sup> Anxiety and depressive disorders are frequently associated with alcohol use disorders, making CT even more effective in this population.

We have found CT to be quite helpful when culturally adapted to Polish and other foreign-born populations. A particularly helpful aspect of cognitive psychotherapy is that it gives patients concrete tasks to work on without much need to address their "feelings," which can be very difficult for these groups. Furthermore, challenging beliefs, such as the idea that a few drinks before going to sleep are helpful to unwind, if approached with cultural sensitivity, can also be very useful.

Among Polish patients (and a number of other foreign-born populations), an immediate reliance on an abstinence model may not be very effective. Therefore, in working with the patient in the case described here, the clinician used the medical evidence of the harmful effects of the patient's alcohol use on his health to challenge the patient's previous perceptions of the benefits and harmlessness of using alcohol to unwind. The clinician then helped the patient explore his history of alcohol use. This allowed the clinician to introduce the concept of alcohol tolerance and its consequences, as a way of challenging the image, often a positive popular one, of someone with a "strong head for drinking." The patient indicated that he viewed having several drinks a day as culturally acceptable and that he did not consider this behavior to be a problem. Equipped with this knowledge, the therapist helped the patient explore the "paradox" of his culturally influenced attitudes towards alcohol: on the one hand, he felt strong pressure to conform to cultural expectations by participating in social alcohol use, while, on the other hand, he was worried that any evidence of loss of control related to alcohol would be considered shameful and a sign of weakness. The patient was then able to acknowledge his fear of being judged as an alcoholic

should he refuse to participate in alcohol consumption, particularly during the anticipated welcoming celebrations that would greet his return to his family and community in Poland.

One of the limitations of CT is that patients are expected to continue their work at home, in particular to practice relaxation and communication skills. Patients who still work as laborers in areas such as asbestos removal often do not feel able to commit to any kind of homework due to the unregulated and unpredictable schedule in this field of work.

### Behavioral Therapy

A broad array of behavioral techniques has been developed and can be used in working with patients with alcohol dependence. Activity scheduling, role playing, relaxation training, graded task assignment, problem solving, exercise, and stimulus control can all be used effectively, if judiciously chosen and integrated.<sup>13</sup> For example, individuals can be desensitized to stimuli associated with consumption, by role playing situations in which the patient may be at risk of using alcohol. Patients can learn relaxation techniques and communication skills to help them avoid relapse in these situations. It is also possible to enhance abstinence-related behaviors and discourage alcohol use with operant conditioning learning. For example, contingency strategies involve giving positive rewards (money, coupons) when the patient remains abstinent or adopts attitudes and behaviors consistent with an alcohol-free lifestyle. On the other hand, alcohol use and non-desirable behaviors (positive urine test, non-adherence to treatment) result in loss of privileges, although aversive strategies are less likely to be effective than positive reward approaches.<sup>14</sup> The ability to verify the patient's self-report with objective testing methods, such as a breathalyzer and/or urine toxicology screen, and the consistent application of consequences (positive and/or negative) are crucial for this approach to be effective.

The patient in the case described here found the suggestion of role playing too "confronting" and incongruent with his communication style; however, he was able to engage effectively in semi-structured discussions and problem-solving techniques. For example, he considered using his health status as a 9/11 survivor as a socially acceptable reason for his "blanket" refusal to consume alcohol, based on his medical reasons for abstinence. He also identified various strate-

gies for managing stress, including plans to grow vegetables and fruit trees, to get a dog as a motivation for exercise and as company in situations not connected with stimuli that would promote alcohol consumption, and to use his spirituality, consciously and strategically, to seek relaxation and "refuge" when confronted with triggers or experiencing cravings.

### Relapse Prevention

The goal of relapse prevention is to prevent a return to a previous pattern of alcohol use following cessation of consumption, or to reduce consumption and harm in the context of a partial remission. It is based on the cognitive-behavioral model of relapse and borrows many elements from cognitive and behavioral techniques. It involves a psychoeducational phase, in which the individual learns to disentangle the effects of various drugs and symptoms of withdrawal and intoxication associated with them. The main goal, however, is to identify factors involved in relapse, including stress and exposure to stimuli associated with alcohol use, and to develop strategies to prevent relapse in such circumstances. Different techniques are used for this purpose, including role playing, semi-structured discussions, and relaxation exercises. This approach is well suited to group therapy, and can be conducted using a manual for therapists and educational materials for patients.<sup>15</sup>

In applying relapse prevention strategies with Polish and other foreign-born WTC responders, clinicians must take into account that many of these patients are in the process of planning to go back to Poland and elsewhere, so that it is essential to develop strategies for continuation of treatment when these patients return to their native countries. Over the course of treatment, our patient's culturally determined belief that the main tool for achieving and maintaining abstinence was his "strong will" gradually evolved in response to psychoeducation, motivational approaches, and the exploration of salient cultural factors and their influences, so that he was able to begin shifting from feelings of shame and self-blame toward goals and strategies for change. Using both anticipated and "What if..." scenarios, the clinician "teased out" and discussed with the patient various examples of stressors and other triggers, such as personal relationships, social pressures, and the stress of readjusting to life back in Poland, that he was likely to encounter upon his return.

## Practitioner's Corner

### Psychodynamic Therapy

Psychodynamic therapy is based on the concept that substance use is a manifestation of intrapsychic issues. The degree to which the therapist intervenes during the session, as well as the structure and duration of therapy, vary considerably depending on the model that is used. Shorter and more structured approaches have recently been developed, which appear most suitable for individuals with alcohol dependence, and these have shown promising results.<sup>14</sup> Although to date hardly any well designed studies have evaluated the effectiveness of these approaches in the treatment of addiction,<sup>14</sup> clinical experience suggests that they are useful in individuals who have been abstinent for a few months, are psychosocially stable, and able to attend sessions on a regular basis.

Provision of psychodynamic therapy to Polish 9/11 responders can be quite difficult, especially when related to treatment of substance abuse. We have found that many patients have a limited concept of and capacity for self-exploration, and that this is influenced by variable educational levels and cultural beliefs regarding talking about one's developmental history and emotions. Many of these patients share the common "masculinity" concept that "men should be men" and should not "complain" about their problems. There is also a cultural norm related to protecting the memory of one's parents and not talking negatively about one's elders or the deceased. In this culture, it is also believed that problems should stay in the family circle and should not be aired in public. Therefore, the usefulness of a psychodynamic therapy approach can be limited in the Polish population as well as in many other foreign-born groups that share similar cultural values. However, when psychodynamic therapy is combined with other approaches, it may help some of these patients gain insight into their behavior patterns.

In cases where early sobriety is achieved, the clinician can then shift the focus to a discussion of a sense of achievements and failures during time spent in the United States and the choice that such patients made to come to the United State in the first place. In response to the clinician's focused "teasing out" of the issues, our patient was able to acknowledge and begin to process a range of deep-seated concerns and "nagging" thoughts and emotions about his coming return to Poland that had been suppressed by his

excessive work schedule and use of alcohol. Such problems are often a source of great anxiety for this population. Patients such as the one described here frequently compare themselves to their friends in Poland who were able to benefit from economic opportunities that the socioeconomic reform of the early 1990s in Poland offered them, developing new careers and achieving high standards of living without the personal cost of separation from family. Thus it is very important to address feelings of personal failure and inadequacy to help patients who have immigrated to the United States deal with the consequences of their choices without resorting to the use of alcohol as a coping strategy.

### Motivational Approaches

Motivational interviewing, a technique developed by Miller and Rollnick in the mid-1980s,<sup>16</sup> was initially based largely on Prochaska and DiClemente's theory of change.<sup>17</sup> The motivational approach facilitates the modification of behaviors such as substance abuse by helping the patient explore and resolve ambivalence associated with change. This technique is characterized by its short duration (one to four sessions in general, but it can be applied in an encounter of less than 15 minutes). The therapist needs to elicit doubt and increase the patient's motivation to change his or her substance use behaviors. The key principles of this approach are self-efficacy, empathy, rolling with the resistance, and promoting discrepancy by highlighting the differences between the current situation and the life expectations of the patient. Based on the motivational approach, Motivational Enhancement Therapy (MET), which consists of 4 interviews followed by 2 follow-up meetings, was one of three treatments evaluated in the Matching Alcoholism Treatments to Client Heterogeneity (MATCH) Project. It was shown to be as effective as CBT and 12 step-based approaches in promoting abstinence and preventing relapse.<sup>12</sup>

Many of the patients treated in the WTCMHP are physically disabled and suffer from psychiatric disorders such as clinical depression, anxiety, and panic attacks, which decrease their motivation and energy level.<sup>2,4</sup> Therefore, a motivational approach can help to break down at least some of the barriers these problems pose to sobriety. For example, making our patient's fears and their sources explicit to him allowed him to identify the risks that giving into

social pressure to drink would create for his life goals when he returned to Poland and to start developing relapse prevention strategies that would maximize his ability to withstand social pressures that he came to identify as harmful and potentially destructive for him.

Spirituality and religious beliefs are very important in many cultures, including the Polish culture, and can be incorporated into the motivational approach to alcohol treatment in foreign-born responders. When he lived in Poland, our patient attended church services on most Sundays with his family, a pattern that continued during his initial years in the United States, where weekly church services offered him a venue for practicing his faith as well as an opportunity to develop and maintain social contacts and exchange information (e.g., about work opportunities). This connection was interrupted when Mr. A. began working 7 days/week at GZ. The subsequent disconnect was perpetuated in the following years by his work schedule combined with the impact of his worsening symptoms and increasing use of alcohol. In discussing sources of support available to him in New York, our patient was able to draw on his past experiences participating in expressions of faith and spirituality and harness these experiences for his current situation. He was able to speak about his feelings of guilt and shame for withdrawing from active religious practice and to make a connection with the shame and guilt related to his alcohol use and his subsequently diminished sense of self-worth and alienation.

### Family Therapy

Familial relationships and attitudes of family members toward substance use may contribute to the emergence of alcoholism and may also have an impact on the patient's recovery. When a family member is affected, this problem can have an impact not only on the individual with alcohol dependence but also on the other family members. Family therapy can help clinicians gain an understanding of the nature of the relationships among the individuals in a family or a group, as well of the role of alcohol use as both a cause and symptom of familial dysfunction. While family therapy often requires individual meetings with the patient and his or her relatives, it always involves meeting with all family members together. The goals include identifying and modifying maladaptive patterns of interactions and behaviors

that may be involved in the addictive behavior and its perpetuation. Furthermore, it is important to support family members who may be affected by the addiction of their loved one. Peer groups for relatives of addicts, such as Al-Anon, can offer valuable support in this regard.<sup>14</sup>

Difficulties may arise in using family therapy to work with foreign-born patients, such as Polish 9/11 responders like our patient, because of beliefs about keeping problems in the family as well as the fact that many of these patients have left their families back in their native countries. Furthermore, many of those who have families in the United States often feel ostracized by them. Since mental health treatment is not a culturally accepted way of dealing with problems in this particular cultural and generational group, many responders feel ashamed and stigmatized and do not disclose to their families the fact that they have sought mental health treatment.

In the case of the patient described above, he was able to accept the importance of including his wife in Poland as the key support in immediate and long-term relapse prevention after he returned to Poland. He was able to explore options for effective ways of informing her of his alcohol dependence and need for support, including access to Polish psychoeducational resources. The clinician also used a structural family therapy framework to highlight for the patient areas of potential family stress and conflict that could arise when he reentered the family unit, involving the realigning of family roles and relationships that had developed in his long absence.<sup>18</sup> While the immediate therapeutic impact of this approach was limited, the process made those potential stressors explicit and enabled the patient to better prepare approaches for coping with them and supported his future relapse prevention strategies. When this is not possible, clinicians can broaden the concept of family therapy into peer support therapy, which can be effective, since, as mentioned above, for many Polish and other foreign-born WTC responders, their co-workers have become their main support group and replace their families for the time being.

### Group Peer Support

Support groups are often based on the 12-step principles developed by Alcoholics Anonymous (AA), which was founded in 1935 by Robert H. Smith and William G. Wilson. It involves meetings of alcoholics, sober or

## Practitioner's Corner

not, where everyone is invited to anonymously share problems associated with drinking. Individuals who maintain a relatively steady sobriety can sponsor and offer peer support outside the meetings. Meetings focusing on other substances (i.e. Narcotics Anonymous, Marijuana Anonymous) or other types of issues (Overeaters Anonymous, Gamblers Anonymous) have emerged over the years. A major advantage of these support groups is their accessibility; it is possible to attend a meeting at almost any time of day in almost any part of the country. On the other hand, some individuals may be uncomfortable in such meetings since this approach involves spirituality, and some groups are reluctant to welcome patients with a mental health problem or those who are prescribed a psychotropic medication. Although there is a dearth of randomized trials on the effectiveness of AA, recent studies suggest that the effectiveness of 12-step approaches in treating alcohol dependence is comparable to that of cognitive therapy and of motivational interviewing.<sup>12,19</sup>

The WTCMHP offers Polish as well as Spanish group therapy services that are based on a supportive and stress management model. Patients in these groups can share their feelings related not only to their struggle with PTSD, depression, or alcohol use but also their frustrations related to worker's compensation, the immigration process, or lack of family support due to physical separation and sparse communication. The group therapy approach can help repair the fabric of the immigrant community, which has become fragmented since 9/11 as many patients stopped working, felt ashamed of their reactions, or started isolating themselves due to depression or posttraumatic stress. Unfortunately, at the same time, some group members may become "drinking buddies" and enable each other in their drinking habits. Within the group, patients may have varied standards of what constitutes "normal" drinking, which could be very different from the general standards accepted in psychiatry.

### Pharmacotherapy

Psychotherapeutic approaches are critical to any intervention addressing alcohol abuse. An increasing number of pharmacological strategies have also been shown to be effective in promoting abstinence and decreasing alcohol use.<sup>14</sup> Naltrexone has been shown to improve numerous outcomes related to alcohol

use, including the chance of return to drinking and risk of relapse.<sup>20,21</sup> although some studies have not found similar results in individuals with chronic severe dependence.<sup>22</sup> Acamprosate is an amino acid that decreases glutamate excitatory activity and promotes gamma-aminobutyric acid (GABA)-mediated neuronal inhibition.<sup>23,24</sup> It is generally started in the post-acute withdrawal phase to decrease craving as well as protracted withdrawal symptoms and thus to promote abstinence and prevent relapse. Disulfiram is an inhibitor of aldehyde dehydrogenase, an enzyme involved in alcohol metabolism. When a patient taking this medication uses alcohol, acetaldehyde accumulates and causes a plethora of unpleasant symptoms such as headache, flushing, nausea, vomiting, hypotension, and anxiety. Other medications have been studied, such as topiramate, selective serotonin reuptake inhibitors, tricyclic antidepressants, ondansetron, baclofen (a GABA<sub>B</sub> antagonist), and rimonabant (a cannabinoid receptor antagonist), but they have yet to be approved by the U.S. Food and Drug Administration as treatments for alcohol dependence.<sup>25</sup>

Pharmacotherapy is often helpful in treating Polish and other immigrant responders in the WTCMHP, because of their general regard for medical professionals and belief in the effectiveness of medication. The patient described in the case above had been treated by his general physician for withdrawal symptoms and cravings prior to receiving any other form of mental health treatment. However, at times, patients have unreasonable expectations that medication is a "magic pill" that will cure their alcohol problems without the need to explore their feelings or change their behaviors. Therefore close coordination of care between the psychotherapist and the psychiatrist is necessary.

### CONCLUSION

The case we have presented in this article shows how accepted treatments for alcohol use disorders can be applied and modified in specific cultural groups and settings, such as in the aftermath of a disaster. Although not the only major ethnic group to be involved in the WTC rescue and recovery efforts, Polish responders represented a sizable population within the 9/11 responder community from which we were able to generalize regarding cross-cultural treatment. Experience acquired from addressing

alcohol and mental health related issues in Polish responders in the WTCMHP provided an opportunity to develop approaches for treating addiction and mental health issues in Polish and other foreign-born patients. The lessons learned from this specific case can inform a broader, culturally attuned approach to treating the many populations who are likely to be touched by disasters in large urban centers. This case also highlights occupational mental health issues germane to maintaining a responder community ready to deal with any future disasters that might occur.

### References

- Herman D, Felton C, Susser E. Mental health needs in New York State following the September 11 attacks. *J Urban Health* 2002;79:322-30.
- Katz CL, Smith RP, Silvertown M, et al. A mental health program for Ground Zero rescue and recovery workers: Cases and observations. *Psychiatr Serv* 2006;57:1335-8.
- Raphael B, Ma H. Mass catastrophe and disaster psychiatry. *Mol Psychiatry* 2011;16:247-51.
- de la Hoz RE, Hill S, Chasan R, et al. Healthcare and social issues of immigrant rescue and recovery workers at the World Trade Center (WTC) site. *J Occup Environ Med* 2008;50:1329-34.
- Osiatynski W. Rehab. Warsaw: ISKRY; 2003.
- Kinney J, Leaton G. Zrozumieć alkohol. Poland: Państwowa Agencja Rozwiązywania Problemów Alkoholowych; 1996. (original title: Kinney J, Leaton G. Understanding alcohol, second edition. St. Louis: MosbyYearbook; 1992).
- www.alkoholizm.com.pl, accessed April 14, 2011
- www.lecznicodwykowe.pl, accessed April 14, 2011
- World Trade Center Medical Monitoring and Treatment Program, Mental Health Center. Consensus findings of the Focus Group of Providers of Mental Health Services to Foreign Born Populations, March 18, 2009 (unpublished results).
- Multicultural Equity and Access Program. Polish cultural profile. Eastern Melbourne: Migrant Information Centre, 2010 (available at [www.miceastmelb.com.au/documents/pdaproject/CulturalProfiles/PolishCulturalProfile2010.pdf](http://www.miceastmelb.com.au/documents/pdaproject/CulturalProfiles/PolishCulturalProfile2010.pdf), accessed January 6 2012).
- Gabriel P, Liimatainen M-R, and the International Labour Office. Mental health in the workplace: Introduction, executive summaries. Geneva: International Labour Office, 2000 (GLADNET Collection. Paper 223). (Available at <http://digitalcommons.ilr.cornell.edu/gladnetcollect/223>, accessed January 6, 2012).
- Project Match Research Group. Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH post-treatment drinking outcomes. *J Stud Alcohol* 1997;58:7-29.
- Beck AT, Wright FD, Newman CF. Cognitive therapy of substance abuse. New York: Guilford; 1993.
- Kleber HD, Weiss RD, Anton RF Jr, et al. Treatment of patients with substance use disorders, second edition. *Am J Psychiatry* 2007;164(4 Suppl):5-123.
- Witkiewitz K, Marlatt GA. Relapse prevention for alcohol and drug problems: That was Zen, this is Tao. *Am Psychol* 2004;59:224-35.
- Miller WR, Rollnick S. Motivational interviewing, second edition: Preparing people for change. New York: Guilford; 2002.
- Prochaska JO, DiClemente CC. Stages of change in the modification of problem behaviors. *Prog Behav Modif* 1992;28:183-218.
- Minuchin S. Families and family therapy. Cambridge, MA: Harvard University Press; 2003.
- Kaskutas LA. Alcoholics anonymous effectiveness: Faith meets science. *J Addict Dis* 2009;28:145-57.
- Srisurapanont M, Jarusuraisin N. Opioid antagonists for alcohol dependence. *Cochrane Database Syst Rev* 2005;Jan 25:(1)CD001867.
- Anton RF. Naltrexone for the management of alcohol dependence. *N Engl J Med* 2008;359:715-21.
- Krystal JH, Cramer JA, Krol WF, et al. Naltrexone in the treatment of alcohol dependence. *N Engl J Med* 2001;345:1734-9.
- Saivin S, Hulot T, Chabac S, et al. Clinical pharmacokinetics of acamprosate. *Clin Pharmacokinet* 1998;35:331-45.
- Center for Substance Abuse Treatment (CSAT0). Acamprosate: A new medication for alcohol use disorders. Columbia, MD: CSAT, Substance Abuse and Mental Health Services Administration; 2005.
- Johnson BA. Update on neuropharmacological treatments for alcoholism: Scientific basis and clinical findings. *Biochem Pharmacol* 2008;75:34-56.