Hurricane Katrina: Experiences of Psychologists and Implications for Future Disaster Response

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The landfall of Hurricane Katrina marked not only one of the most significant and destructive natural disasters for the United States in recent history, but also a new benchmark in challenges faced by psychologists providing services. The authors explain their roles following the hurricane, describing not only local activities for recovery but efforts conducted in the Gulf Coast as well. Experiences and perceptions of the first author, who was deployed to the Gulf Coast on numerous occasions, are highlighted. In addition, psychological assessments were carried out with a small number of displaced Katrina survivors who were relocated to the authors’ local community. The authors document many of the challenges faced by psychologists and other mental health workers during relief efforts in the Gulf Coast, concluding with a set of recommendations for future disaster-relief initiatives regarding such issues as ways in which psychologists can participate in disaster-relief efforts, challenges faced when implementing interventions, cultural competency, community preparedness, and scientific research.

Keywords: trauma, disaster, Katrina, cultural competence

Editor’s Note. This article was submitted in response to an open call for submissions about psychologists responding to Hurricane Katrina. The collection of 16 articles presents psychologists’ professional and personal responses to the extraordinary impact of this disaster. These psychologists describe a variety of roles, actions, involvement, psychological preparation, and reactions involved in the disaster and the months following. These lessons from Katrina can help the psychology profession better prepare to serve the public and its colleagues.—MCR

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Hurricane Katrina developed in the Atlantic Ocean as a hurricane on August 23, 2005 (National Weather Service, 2005). On August 25, the storm traveled over the Florida peninsula and, on August 29, made landfall near New Orleans, Louisiana. Before, during, and immediately following the storm, relief efforts were carried out by several local, state, and national government agencies, as well as numerous relief organizations. However, it quickly became apparent that these agencies were sorely lacking in light of the immensity of the many challenges presented by the storm and its aftermath. Although psychologists were only a small part of the relief efforts following Hurricane Katrina, their clinical, research, and applied skill sets have contributed significantly to the ongoing recovery efforts in the Gulf Coast.

Our Roles

Over the past 23 years, the Stress and Coping Lab at Virginia Tech (and more recently the Recovery Efforts After Child Trauma [REACT] team) has responded to and examined the impact of both technological and natural disasters. Experiences with a variety of natural disasters, including hurricanes, wildfires, and upwards of 200 residential fires across five states, have afforded the lab a solid theoretical and empirical knowledge base. Insights gained from these endeavors have guided much of our thinking and actions during the acute and long-term phases of the hurricane’s aftermath.

Throughout the recovery efforts of Hurricane Katrina, we took on many roles, including consulting with local, state, and national government agencies, advising the White House, and training crisis workers and counselors in the areas of disaster mental health and cultural competence. Several of these recent efforts were made possible through membership in the Disaster Technical Assistance Cadre (DTAC) sponsored by the Substance Abuse Mental Health Services Administration (SAMHSA, a division of the U.S. Department of Health and Human Services). A brief overview of deployments to the Gulf Coast and related cities follows.
During the initial two deployments of the first author (2 and 6 weeks post-hurricane) to Baton Rouge, Louisiana, and Jackson, Mississippi, the primary role of two teams of mental health workers was to assist state emergency directors in the coordination of the mental health response to Hurricane Katrina. One of the first steps in gaining an understanding of the storm’s devastation was an automobile and walking tour of New Orleans. Another important function of the teams was attendance at numerous meetings with a variety of mental and physical health professionals and military personnel at temporary disaster shelters, centers, and military command posts. Conferences with representatives from numerous organizations, including the Federal Emergency Management Agency (FEMA), the American Red Cross (ARC), and the Centers for Disease Control and Prevention (CDCP), were essential to the coordination of multiple efforts. The ultimate goal of these meetings was to establish and, at times, strengthen working relationships with national, state, and local officials.

Formal and informal interviews with children, parents, and other adults affected by the storm were also undertaken. While serving as team leader during the second deployment, the primary task of the first author was the organization and coordination of the day-to-day activities of team members (consisting of eight mental health professionals). Overseeing their safety, along with their mental and physical health, was an essential role. Two additional tasks that ranked high on the priority list were grant writing and advocating for training in cultural competence and disaster behavioral health.

In light of his background as a clinical psychologist and trauma researcher, the first author was asked to make formal recommendations to determine the extent of exposure and potential psychosocial consequences of the storm on children and adolescents. A primary goal of this endeavor was to inform mental health workers of appropriate screening, assessment, and intervention strategies. Another key concern was the racial, cultural, and ethnic diversity of storm survivors. Specifically, the team provided insight into methods for becoming culturally and ethnically sensitive when approaching, interacting, screening, assessing, and treating those in need of assistance. The implications of these factors for all phases of the recovery process for both survivors and mental health professionals were enormous.

The first author made two later trips (8 and 9 weeks post-hurricane) to Jackson, Mississippi, and Atlanta, Georgia, for the purpose of participating in two workshops sponsored by the U.S. Department of Education. In his role as a DTAC consultant, clinical psychologist, and disaster expert, the first author shared his experiences from the Gulf Coast. In addition, he also had opportunities to inform teachers, school administrators, mental health professionals, and community leaders about the knowledge base describing children and adolescents’ responses to disasters, as well as empirically supported and empirically informed interventions. He is currently serving as a member of an advisory committee for the U.S. Department of Education.

In December 2005, the first author was asked to assist First Lady Laura Bush by briefing and preparing her for a meeting with a group of children and their parents at an event in Metairie, Louisiana. He was invited to accompany her to this event to discuss issues related to loss, coping, and recovery. Since that time, he has met with a member of Mrs. Bush’s staff at her office in the White House to discuss issues related to children affected by the storm, as well as trauma-related initiatives of our team. Providing updates on continuous initiatives with children of the Gulf Coast is an ongoing activity. This exemplifies how we as psychologists are able to apply our knowledge, expertise, and skills to real-world problems.

Three subsequent deployments (January–March 2006) targeted the topic of cultural competence and disaster behavioral health. The mobilization of staff to disaster areas to attend to the emotional needs of survivors defines disaster mental health operations (SAMHSA, 2006). Consistent with both DTAC teams’ recommendations to provide training in cultural competence to state and local professionals and paraprofessionals, innovative steps were initiated to achieve this goal. The first stage in this process was to carry out focus groups with approximately 100 crisis counselors to ascertain the needs of storm survivors and levels of proficiency in the domains of disaster mental health and cultural competence.

In March 2006, the Louisiana Department of Mental Health charged four professionals in disaster behavioral mental health and cultural competency with the task of developing and implementing a training curriculum to enhance the skills of crisis workers in delivering effective, culturally and linguistically appropriate strategies and interventions. A primary goal of this effort was to address the unique mental health needs of the storm survivors. Team members included Barbara J. Bazron, Russell T. Jones, Mareasa Isaacs, and Kermit A. Crawford. As an initial step in developing the curriculum, nine focus groups were conducted to gather specific information from crisis workers while providing services to survivors of the storm. Five specific objectives of the focus groups were to (a) determine the extent to which survivors had received services and showed progress toward recovery; (b) identify the most significant concerns facing survivors, including children and the elderly; (c) determine the type of assistance needed by trainees to enhance their ability to provide culturally and linguistically competent disaster behavioral health care services; (d) determine the demographics and cultural strengths of respondents; and (e) determine the extent to which crisis workers have been able to provide disaster behavioral health services within the context of the cultures of those people being served. During the analyses captured via the Focus Group Session Questionnaire and notes obtained by facilitators, each of the four facilitators carried out a manual content analysis. They identified common and divergent themes, which are summarized below.

Information regarding training needs, format, and focus provided a clear framework for developing a curriculum and carrying out training. Participants overwhelmingly requested development of a curriculum and training to provide concrete, practical tools and strategies to enhance cultural sensitivity during disaster relief. Consequently, team members developed a training manual that addressed issues raised during the focus groups. Two-day seminars were carried out in Baton Rouge and New Orleans, Louisiana, in August 2006. (More information on this training and copies of the manual can be obtained on request from the first author.)

**Katrina-Related Efforts in the Local Community**

In addition to trips to the Gulf Coast, in September 2005, the Virginia Tech REACT team was invited to perform psychological and needs-based assessments with storm survivors by the local ARC chapter and the director of an evacuation shelter. In addition,
a description of services within the local community was provided. Following a brief social interaction with survivors, an assessment area was created where families could voluntarily participate in individual interviews to objectively determine levels of distress. Instruments for children and adolescents included the Hurricane Assessment and Referral Tool for Children and Adolescents, developed by the National Child Traumatic Stress Network (NCTSN, 2005), the Child Reaction to Traumatic Stress Scale–Revised (Jones, Fletcher, & Ribbe, 2002), and the Posttraumatic Stress Disorder/Acute Stress Disorder module of the Anxiety Disorder Interview Schedule for DSM–IV (Albano & Silverman, 1996). For adults, the team administered the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) and the Posttraumatic Stress Disorder/Acute Stress Disorder module of the Anxiety Disorder Interview Schedule for DSM–IV (Di Nardo, Brown, & Barlow, 1994). We provided individuals with immediate feedback and, when appropriate, referrals to the REACT Clinic and other local agencies.

Longitudinal Assessment of Psychological Functioning

The REACT team established a partnership with the Hurricane Katrina Community Advisory Group (spearheaded by Ronald Kessler at Harvard University) in November 2005. Its purpose was to carry out a series of studies assessing the short- and long-term mental health impact of the storm on adults. The team employed a random digit dialing method between January and March 2006 to collect data from 1,043 English-speaking storm survivors (ages 18+). By using both random digit dialing and ARC frames of hurricane survivors, the researchers were able to access households on file prior to the storm as well as households applying for ARC assistance after the storm. For residents who evacuated to various parts of the country, simply dialing their cell phone numbers enabled contact with them.

Comparisons of prestorm levels of functioning with poststorm functioning were made possible through a previous survey carried out by Kessler and colleagues (2004). Primary findings suggested elevated levels of both posttraumatic symptoms and depression. In addition, levels of suicidality were lower than hypothesized (Kessler, Galea, Jones, & Parker, 2006). Interpretation of these findings and further data collection are presently ongoing.

Lessons Learned and Recommendations

Getting Into the Field

Steps to rapid deployment. One of several ways to facilitate rapid deployment to disaster sites is through the DTAC program. The first author felt that his level of preparedness was greatly enhanced by a 3-day workshop held in May 2005 in Bethesda, Maryland. This training (the Cadre of Consultants Initiative Orientation) was developed in the fall of 2004 with the goal of ensuring that needs related to disaster preparedness, as well as response and recovery, would be successfully met in crisis situations.

Training was carried out by staff at SAMHSA, as well as individuals from partner groups, including the NCTSN and the National Center for Posttraumatic Stress Disorder. Experts in the areas of all-hazards disaster planning and response, substance abuse, psychosocial impact, and the SAMHSA grant programs participated.

One of several problems witnessed by the first author during his deployments was a lack of coordination and structure amid the influx of psychologists deployed to various disaster areas of the Gulf Coast. This lack of organization and structure appeared to compromise the effectiveness of psychologists responding to the disaster. Future coordination efforts may consist of simply having organizations such as the ARC or FEMA encourage psychologists to contact whichever agency is responsible for deploying psychologists. This would allow the agencies to first assess whether the psychologists’ presence was needed, and then direct them to areas where they would be of greatest service. In addition, longer deployments might well facilitate the continuity and completion of various initiatives. It may prove beneficial for psychologists to have a preassembled kit including necessary instruments, contact numbers, office supplies, recording devices, and other such materials. Logistical concerns are of the utmost importance in disaster areas, and the need to coordinate and partner with local agencies and gatekeepers should be an important component of any deployment effort. When such planning does not take place, problems are likely to arise. For example, FEMA was criticized for taking motel rooms from families and giving them to personnel deployed to the area (Hsu, 2005).

Similarly, if existing agencies are not made aware of deployments in advance, it may be difficult to use consultants’ expertise in a timely and balanced fashion. This problem was noted shortly following the 9/11 terrorist attacks, when large numbers of psychologists were deployed to New York City. Unfortunately, the skills and expertise of this group were not capitalized on; directly following the event, survivors were more concerned with immediate needs, including food, housing, medical treatment, and restoration of infrastructure, than with issues related to mental health treatment (Seely, 2003). In summary, psychologists need to coordinate their deployment with existing agencies and community representatives prior to entering the disaster area.

Licensure. An important consideration for mental health workers responding to disasters is licensure qualifications. Most mental health workers are licensed by a state government or board and not at a national level. Immediately following Hurricane Katrina, the legislature of the State of Louisiana waved licensure and certification requirements on a temporary basis to allow mental health workers to provide primary care to storm survivors. However, this information was not made available; as a result, some psychologists were turned away and not allowed to practice in the disaster area (American Psychological Association, 2005a). Psychologists displaced by the storm who desired to provide services in a new state needed to obtain a temporary license or an exemption from licensure rules. However, the rules for obtaining temporary licensure or being relicensed vary by state. In the future, psychologists should familiarize themselves with an affected state’s board of psychology for licensure information to determine what is necessary to achieve adequate licensure when working in a disaster area. We also recommend that directors of mental health organizations seek immediate, temporary licensures for their providers to allow a smooth and efficient ingress of psychologists participating in disaster-relief efforts.

Impact on independent practice. Following the storms, many psychologists in the affected area found themselves struggling to
rebuild their communities and support those in need of services. Many were forced to not only deal with personal issues of safety and recovery, but also difficult business decisions in an environment marked by uncertainty. In the future, according to the American Psychological Association (APA), when clinicians are able to access their offices, they should quickly assess the damage and losses, review insurance policies, and talk to an insurance representative immediately to begin the claims process (APA, 2005b). In addition, it is important for clinicians in private practice to review their business plans to determine whether goals, services, clientele, referral sources, and communication with these sources are viable, given the disaster’s impact. After the initial assessment of the damages, they should consider the following options: close, sell, relocate, or reopen the practice.

For psychologists desiring to practice provisionally in a disaster area, temporarily closing one’s own practice to assist with recovery may significantly affect their functioning. It is important to determine whether one’s services are essential and to assess the effects of potential disruptions to treatment of one’s current clients. With all variables considered, we recommend that psychologists perform a cost–benefit analysis of temporarily closing their practice before making a final decision. Psychologists wishing to provide assistance to disaster-stricken areas should have a contingency plan established so as to not jeopardize their clients’ well-being or their practice’s economic welfare. It is important to generate referral options for clients, especially if the clinician plans to be away for an extended time. In addition, alternative treatment options, such as telephone or online therapy services, should be provided to clients if applicable.

**Travel expenses.** A very practical concern for psychologists considering assisting in crisis situations such as Hurricane Katrina is the cost. The cost of travel to disaster areas depends on the deploying organization. For example, members of the SAMHSA DTAC team who traveled to and from the Gulf Coast were reimbursed by SAMHSA. However, unlike SAMHSA, many other volunteer organizations may be unable to reimburse one’s travel-related expenses. We advocate full-time disaster-relief positions and stipends for psychologists and other mental health workers associated with such organizations as FEMA, ARC, and the APA Disaster Response Network.

**Communication systems.** An additional recommendation for psychologists in the field includes developing more sophisticated and effective communication systems (i.e., cell phones, landlines, and two-way radios) for consultants, providers, and volunteers. The hurricane significantly impaired the functionality of both cell phones and landlines in many communities. Psychologists who intend to work in disaster areas should stay informed about the latest communication systems employed in such areas. By building relationships and working with local fire departments and rescue services prior to disasters, psychologists can become familiar with the use of such technologies.

**Issues Related to Safety, General Well-Being, and Vicarious Traumatization**

A major concern for psychologists and other mental health professionals deployed to disaster sites is personal safety. It is important for psychologists to be aware of health concerns and dangers in disaster areas. These include the presence of environmental toxins and other health hazards that may later lead to disease and illness. One need only recall first responders’ unfortunate bouts with physical problems following 9/11 to note these dangers. Physical examinations and tetanus shots prior to traveling to disaster sites are highly recommended. During exit procedures, screenings for personal distress and organizational debriefings are also recommended.

Another problem likely to be encountered by psychologists is the potential psychological impact of working with those suffering from trauma, referred to as vicarious traumatization, compassion fatigue, or more simply burnout. Madrid and Schacher (2006) described vicarious traumatization as emotional or psychological reactions triggered by the experiences of empathetic engagement with clients who are survivors of trauma. This reaction is often considered an inescapable aspect of trauma work and can lead to depression, anxiety, substance abuse, maladaptive coping, and neglect of self-care in health care professionals. Findings suggest that the prophylactic use of self-care techniques is often neglected until serious signs of stress develop. To combat this trend, we encourage psychologists working in disaster areas to periodically engage in techniques designed to lower stress while deployed in the field. When feasible, it also may be advisable to have psychologists in disaster areas undergo brief psychological screenings and assessments at various intervals to formally evaluate them for any signs of vicarious traumatization.

**Issues Related to Intervention**

Psychologists and other mental health professionals should be aware of the empirical literature documenting risk and protective factors of those affected by disaster. Knowledge of such factors will afford a comprehensive evaluation of each, as well as the provision of screening, assessment, and intervention strategies targeting them. Parekkal, Jones, and Olleandick (2006) discussed the presence of protective factors shown to lessen negative reactions to disasters, which include availability of social support, coping strategies (i.e., active, avoidance, religious), and cultural strengths (i.e., beliefs, identity, traditions). A protective factor that may be of particular relevance for those in the Gulf Coast is religious coping styles, as African Americans have reported higher church attendance, more reading of religious materials, and greater pursuit of spiritual comfort through religion than Caucasians (R. J. Taylor, Chatters, Jayakody, & Levin, 1996). Following a traumatic event, the use of spiritually based coping has been found to be inversely related to levels of distress in African American children and adolescents (Parekkal et al., 2006).

Awareness of the timing of intervention is also of extreme relevance. For example, decisions as to when interventions should actually be carried out with survivors should be based on empirically driven data rather than one’s passion, zeal, or desire to help those in great need. Current science suggests that early interventions may do more harm than good, because they may prevent individuals from recovering more naturally; most individuals will recover without intervention (Litz, Gray, Bryant, & Adler, 2002). Whereas treatments such as debriefing are discouraged because of a lack of empirical support, we advocate evidenced-informed and evidenced-based cognitive–behavioral interventions.

Although the clinical literature regarding treatment of traumatized children describes a wide variety of interventions, including...
criterion initiatives, psychoanalytic techniques, creative arts, play therapy, eye movement desensitization and reprocessing, and pharmacotherapy (Cohen, Mannarino, & Rogal, 2001), there appears to be no clear consensus about an effective treatment of posttraumatic stress disorder with this population. Variants of cognitive–behavioral therapy, which combines information about expected reactions (psychoeducation) to stress and trauma, relaxation training, coaching on coping strategies, and direct exposure to traumatic studies, have been used in the few studies described below that address traumatic stress, posttraumatic stress disorder, and trauma symptoms.

In similar trauma research, Cohen and colleagues reported significant improvements for a trauma-focused cognitive–behavioral therapy (TF-CBT) treatment as compared with child-centered therapy for 8- to 14-year-old children (Cohen, Deblinger, Mannarino, & Steer, 2004). This TF-CBT approach specifically targeted posttraumatic stress disorder symptoms with the following components: training in coping skills and expressing feelings; identifying thoughts, feelings, and behaviors; gradual exposure to the trauma by creating a trauma narrative (writing and illustrating their personal story); parent–child sessions; psychoeducation; and parental management skills. Such an approach, which combines adult posttraumatic stress disorder treatment and treatment strategies for child anxiety, is receiving growing support as a treatment for child abuse trauma. Overall, however, given the high prevalence of child trauma, the treatment efficacy literature for posttraumatic stress disorder, including trauma following natural disaster, is in its infancy (T. L. Taylor & Chemtob, 2004). In the absence of a convincing body of empirical literature showing superior efficacy of a specific treatment modality, clinicians working with child survivors of Hurricane Katrina and other natural disasters must adapt treatment models such as those described by Cohen and colleagues (2004) or base treatment decisions on empirical evidence combined with more subjective criteria (e.g., what they are most comfortable using, what has worked best in their own experience, etc.; Cohen et al., 2001).

Stein and colleagues (2003) evaluated the effectiveness of a school-based intervention to reduce the symptoms of posttraumatic stress disorder, anxiety, and depression related to exposure to violence. The intervention was a 10-session cognitive–behavioral therapy group called the Cognitive–Behavioral Intervention for Trauma in Schools (CBITS), which was designed for use in inner-city schools and mental health clinics with a multicultural population. The CBITS intervention incorporates cognitive–behavioral skills in a group format, using a mixture of didactic presentation, age-appropriate examples and games to solidify concepts, as well as individual exerxions on worksheets during and between sessions. The CBITS approach was reported to significantly reduce self-reported symptoms of posttraumatic stress disorder and depression at a 3-month follow-up when compared with a delayed intervention comparison group.

Finally, the Stress and Coping Lab of Virginia Tech employs an evidence-informed treatment strategy aimed at ameliorating the adverse effects of disaster exposure and posttraumatic stress disorder. This treatment, which employs a cognitive–behavioral approach, uses such components as deep muscle relaxation, diaphragmatic breathing, rehearsal plus evacuation skills (Jones & Randall, 1994), grief counseling, and tools for strengthening social support. Given that resource loss increases psychological distress posttrauma (Hobfoll, 1998), an additional aim of this intervention strategy is to put disaster survivors in contact with local recovery community organizations to facilitate the replacement of important documents and possessions. By combining therapeutic efforts with the means to replace disaster survivors’ physical belongings, our treatment strategy helps to put these individuals on the path to recovery (Jones, Hadder, Moore, Immel, & Sirbu, 2006).

**Cultural Sensitivity for Psychologists Working in Disaster Relief**

Cultural sensitivity was (and remains) particularly important in the Gulf Coast, as upwards of 67% of the impacted communities were predominantly African American (U.S. Census Bureau, 2000). In addition, data released by the U.S. Census Bureau (2006) showed that nearly 1 in 10 Louisiana residents fled the state following the hurricane season of 2005. Louisiana’s population decreased from approximately 4,068,028 from January through August 2005 to approximately 3,688,996 from September through December 2005, as estimated by the bureau. This is a loss of 379,032 residents, or 9.32% of the state’s population, following the 2005 hurricane season and highlights the fluctuation of different groups of people.

Furthermore, some hurricane-affected parishes lost huge numbers of residents, whereas others withstood significant increases as displaced hurricane survivors relocated throughout the state. For example, in one extreme population loss, the coastal Louisiana parish of St. Bernard (southeast of New Orleans) saw 94.8% of its population leave and not return by January 1, 2006. St. Bernard’s population fell from 64,576 on July 1, 2005, to 336,16 months later, a loss of nearly 61,215 residents. In addition, detailed data from the U.S. Census Bureau (2006) showed that the number of people per household statewide in Louisiana increased, as families moved in together and neighbors accommodated one another. The average household size in Louisiana grew from 2.47 to 2.55 people per household, whereas the total number of households decreased from 1,645,112 to 1,448,443, a loss of nearly 12% of the state’s households. In addition, the percentage of Louisiana residents who moved in the past year rose from 15.2% prior to the hurricanes of 2005 to 17.8% following the disaster. Data indicate that people moved regardless of race, income, family size, and economics. The U.S. Census Bureau has noted that this relocation effort may be the largest postdisaster migration in U.S. history, given that it involved individuals across all social divides and groupings. This vast shift in population demographics represents a significant challenge to psychologists in developing and maintaining culturally competent practices.

In addition to training in the basics of disaster preparedness, response, and recovery, it is essential that consultants be trained in cultural competence. Cultural competence may best be described by three characteristics: obtaining knowledge about specific people and groups of people; integrating and transforming this knowledge into specific standards, policies, practices, and attitudes; and using these tools to increase the quality of services and produce better outcomes (Davis, 1997). During countless interactions with African American survivors shortly after the first author’s initial visit to the Gulf Coast and his most recent visit in March 2007, they raised many concerns regarding linguistics, issues of trust, access to resources, and cultural differences. A detailed discussion
of each of these issues and strategies to deal with them is discussed in a recent book chapter (see Jones, Hadder, Carvajal, Chapman, & Alexander, 2006). Simply put, it is essential to have psychometrically sound and culturally sensitive screening and assessment instruments. The endorsement of intervention strategies should be based on empirical findings stemming from the information gleaned during the screening and assessment phases with people of color and other diverse groups. Unfortunately, to our knowledge, few if any validated cultural competence instruments exist. Our lab is presently initiating efforts to produce such instruments.

Members of ethnic minority and marginalized groups are more likely to accept assistance from individuals with whom they have formed meaningful relationships prior to the disaster (Jones, Hadder, Carvajal, et al., 2006). Thus, psychologists will benefit from partnering with established community organizations within a disaster area, in that aligning with trusted organizations can increase the extent to which psychologists are viewed by all ethnic group members as a viable source of assistance following a disaster. In addition, targeting diversity among group members in the planning of disaster mental health services can likewise increase the trust with which diverse ethnic groups view psychologists. Psychologists need to think outside the box. Partnering with agencies and organizations such as the National Association of Black Psychologists, the National Association of Latino Psychologists, the National Association of Black Social Workers, the National Medical Association, the National Black Nurses Association, and members of the Congressional Black Caucus, may well provide the necessary expansive knowledge base to build a greater capacity to assist the underserved. Finally, collaborating with community agencies allows psychologists to obtain valuable information on the most effective ways to reach out to minority group members in a disaster area, as well as providing an accurate assessment of these groups’ primary needs (Jones & Hadder, 2006).

Community Preparedness: Transitioning Into the Community

From our combined experiences with the REACT team, as well as numerous trips to the Gulf Coast, we strongly advocate for a paradigm shift from existing approaches to disaster preparedness. Rather than adopting traditional approaches where reliance on state and national resources is advocated, or where focus is aimed at personal actions in the acute phase of disaster situations, we argue strongly for a community-based approach that draws on resources and strengths of the community prior to, during, and after traumatic events.

In our collective experience, we have noted that during the acute phase of a disaster, survivors are more likely to receive help from others than during later phases of the recovery effort. In war, it is often said that “there is no color distinction in fox holes,” and in fact, distinctions and differences are minimized and similarities are magnified, leading to joint efforts to produce mutual survival. However, at later phases during the recovery process, individuals appear more selective in whom they are willing to turn to for help. More often than not, survivors will call on those with whom they have established relationships prior to the event. Relatives, friends, churches, and community agencies are more likely to be called on than “outsiders.” Hence, the need to build relief capacity by establishing relationships with individuals and groups within the community is essential to the well-being of residents. Our REACT program, which is based on the Child Development Community Policing Program (CDCP; Murphy, Rosenheck, Berkowitz, & Marans, 2005) at the Yale Child Study Center, advocates such community-based intervention approaches. The CDCP was originally designed to train police officers in developmentally appropriate ways to interact with the children they encounter on domestic violence calls, coordinate with on-call clinicians, and lessen the negative effects of the traumatic events that these children experience. REACT, which implements a component of the CDCP model whereby firefighters are encouraged to call clinicians to the scene of residential fires, represents one such pre-existing community-based program that survivors are likely to call on during the acute as well as long-term phases following individual and large-scale disasters.

We recommend that psychologists accomplish this by making themselves aware of what organizations are most important within a particular community (i.e., local government, volunteer groups, religious organizations, etc.) and contacting representatives from these organizations for advice on how to proceed within that community. The pursuit of such culturally competent practices can allow for the smoother and more efficient deployment of psychologists within a disaster area.

Scientific Research

Our final set of recommendations deals with the all-important area of research. One of the most important contributions that the social sciences have to offer disaster-relief efforts is our science. When the first author left his initial deployment to the Gulf Coast, he had the following thought: “To achieve success with this daunting effort it will take our best science and utmost sensitivity.” The following recommendations, based on our scientific knowledge, were developed by a group of national and international experts in disaster mental health at a consensus conference titled “Mental Health and Mass Violence.” This meeting convened several weeks after the attacks of September 11, 2001. The following recommendations emerged: (a) Research and program evaluation are critically important to mental health disaster response; (b) the scientific community has an obligation to examine the relative effectiveness of interventions; (c) a national strategy should be developed and implemented to ensure systematic data collection, evaluation, and research during and after mass violence and disasters; (d) if optimal forms of intervention are unknown, there is an ethical duty to perform sound research to improve all aspects of intervention; (e) systematic evaluation activities should be conducted with mental health professionals; (f) a standard taxonomy should be developed in research; (g) a push to inform the broader community is essential to the well-being of residents. Our REACT program, which is based on the Child Development Community Policing Program (CDCP; Murphy, Rosenheck, Berkowitz, & Marans, 2005) at the Yale Child Study Center, advocates such community-based intervention approaches. The CDCP was originally designed to train police officers in developmentally appropriate ways to interact with the children they encounter on domestic violence calls, coordinate with on-call clinicians, and lessen the negative effects of the traumatic events that these children experience. REACT, which implements a component of the CDCP model whereby firefighters are encouraged to call clinicians to the scene of residential fires, represents one such pre-existing community-based program that survivors are likely to call on during the acute as well as long-term phases following individual and large-scale disasters.

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In conclusion, we strongly advocate for greater attention to the area of disaster behavioral health. Given the events of the past 2 years, the predictions for natural and technological disasters, as well as the threat level for acts of terrorism, this need is obvious. Although our work has been challenging, time consuming, and at moments, seemingly overwhelming, it has also been highly stimulating and rewarding. Such challenges provide a real opportunity to apply our science to the real-world problems of our times. Truly, the harvest is ripe and the need for laborers is plentiful.

References