 Lessons From Katrina: Disaster Mental Health Service in the Gulf Coast Region

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In this article, 4 mental health professionals provide firsthand accounts of experiences as volunteers in the Gulf Coast region following Hurricanes Katrina and Rita in the fall of 2006. These accounts are provided with the goal of informing psychologists and other mental health providers about the role of volunteers from a frontline perspective. The authors offer these observations as a compliment to formal training in disaster preparedness that psychologists might receive for volunteer service in the wake of a devastating disaster. Specifically, the authors discuss the training they received, the settings in which they worked, and the client needs and mental health skills they used to meet those needs. Last, the lessons the authors learned about providing disaster mental health services are discussed. It is hoped that these observations might inspire others to lend their expertise and compassion in response to future catastrophic events.

Keywords: disaster mental health, Hurricane Katrina, psychological first aid

Accompanying a client to the grave of her partner who died following a devastating hurricane, listening with a client to a saved cell phone message informing the client that her missing father was alive, packing and carrying bags of groceries to the cars of elderly residents, holding the hand of a man in advanced stages of untreated cirrhosis, completing Federal Emergency Management Agency forms for an overwhelmed resident, making sure relief workers are coping and taking adequate breaks—these are just a few of the activities we performed as American Red Cross (ARC) Disaster Mental Health (DMH) workers following the devastation of Hurricanes Katrina and Rita. We are four mental health professionals in a university setting who volunteered for first-time service with the ARC in September and October of 2005. At the time of our volunteer experience, Kennard Nears was pursuing a doctoral degree in counselor education and was a nationally certified counselor and a licensed professional counselor in North Carolina. The rest of us were instructors or faculty in a university setting. We each had a doctorate in psychology and were licensed at the state level; two of us were Health Services Provider psychologists.

The purpose of this article is to inform psychologists and other mental health professionals about this gratifying form of mental health service delivery by sharing our experiences as volunteers. There are abundant training materials available online (e.g., Web sites for Centers for Disease Control and Prevention, The National Child Traumatic Stress Network, International Society for Traumatic Stress Studies, and U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration) and a rapidly growing literature for disaster preparedness. There are journals and newsletters (e.g., NCPTSD Clinical Quarterly) as well as books (Reyes, 2006; Ritchie, Watson, & Friedman, 2006; Young, Ford, Ruzek, Friedman, & Gusman, 1998) devoted to the topic. Our goal was to provide a frontline perspective to supplement training and reading of the literature that mental health professionals might pursue in preparation for this type of service. Specifically, we describe our preparation for deployment, the mental health services we provided, and lessons we learned.
Marc A. Grimmett was the first to be deployed, and he served in Centreville, Mississippi, during the last 2 weeks of September. Kennard Nears volunteered from mid-September to early October, and he was deployed to Mobile, Alabama. Mary E. Haskett and Susan Smith Scott served in the city of New Orleans, Louisiana, during the last 2 weeks of October. Our experiences, therefore, relate to immediate disaster recovery assistance; the experiences of others who served in later stages of recovery could be quite different from ours. As mental health volunteers with the ARC, we were required to serve in the Gulf Coast region for 2 weeks. The 2-week service was ideal. We had time to gain a reasonable understanding of the region and our roles as mental health volunteers and to provide service to a broad range of clients, but we were not unduly burdened by the absence from home and work. None of us carried private practice caseloads, so there were no complications associated with leaving clients for 2 weeks. As a graduate student, Nears completed most of his course requirements within a few weeks of his return from deployment. The faculty members made arrangements for course coverage. For example, Smith Scott converted lecture material into self-study and group project modules.

Preparation for Service

We were trained by our respective local ARC chapters as DMH volunteers through the Partners for Effective Emergency Response training program. Training was accelerated because of the immediate need for mental health professionals in the Gulf Coast area. Information on provision of mental health services in large group settings was the primary focus of training. In addition to discussion of the reality of mental health services in a disaster area, the predeployment orientation included an overview of the ARC, descriptions of the disaster area and possible hardships such as extreme heat and poor air quality, and information about the Gulf Coast area and its population. In addition, we received information about working with diverse populations, sensitivity and confidentiality, and personal care and safety. We were told to prepare for harsh conditions and to travel light, using backpacks or duffel bags that we could easily carry.

All volunteers who served with the ARC, regardless of their role (e.g., nurses, forklift operators), were trained in the provision of psychological first aid. However, volunteers were told to seek the assistance of a mental health volunteer when (a) children were involved, (b) a death or serious injury had occurred, (c) pets had been lost, (d) homes had been damaged, or (e) people seemed confused or depressed. Nearly everyone in the Gulf Coast region met at least one of those criteria. Thus, there was a need for a very large number of mental health professionals. The ARC response was massive, yet we agreed the response was reasonably well organized under the circumstances. As of October 27, 2005 (the timeframe of our deployment), ARC mental health professionals had logged more than 800,000 mental health contacts following Katrina and Rita (American Red Cross, 2005). A “contact” could range from an informal conversation to assess mental health status to an hour-long problem-solving session to locate needed resources for a client (e.g., tarp for a roof, medication refill). Number of daily contacts varied by location and specific assignment, but 50–75 contacts per day was not unusual.

In regard to preparation, we concur that this type of service requires far more than simply possession of a professional license and training in disaster relief. Before deployment, potential volunteers should ask themselves the following questions: “Am I able and willing to serve a variety of client needs in nontraditional settings?” “Can I function in the midst of chaos and unpredictable situations surrounded by incredible stress, grief, and loss?” “Can family and work responsibilities allow me to be away for at least 2 full weeks?” “Can I function in extremely harsh, adverse conditions?” and “Do I meet the stated requirements for physical health, mobility, and strength?”

Settings of Service

Once we arrived at our destinations, we met with the local mental health supervisor to receive a brief orientation and our assignment for the following day. Mental health professionals worked in a variety of settings, and responsibilities varied somewhat for each type of assignment. Each of us served for a period of time in a client service center. For example, Grimmett was an on-site cosupervisor for up to 18 mental health volunteers who were part of a 70–75 member ARC team. The team was deployed to Centreville, Mississippi, to establish a client service center. In only 3 days, an abandoned textile factory was equipped with tables, chairs, computers, phones, faxes, and a copier so volunteers could assist clients with their immediate financial and housing needs. In addition, food, water, drinks, clothing, diapers, cleaners, and other products needed for daily living were distributed. The center served an average of 400–500 clients daily but served up to 700 clients on some days. Many had traveled to more than one location in search of ARC service centers, often acquiring information about centers by word of mouth only. Some clients reported making it to a service center, only to have it close before they received assistance. Unfortunately, this was a common experience that caused clients anxiety as they worried whether they would receive adequate assistance. ARC staff had few assurances related to service center resources and longevity of operation. In addition, all ARC staff members were taught to inform clients that the purpose of the ARC was to provide immediate crisis assistance, not long-term solutions.

In addition to being the primary providers of mental health care, we served in various capacities within the client service center. For example, it was important to help with daily labor tasks, such as unloading trucks, setting up, and cleaning the facility. Our work started in parking lots, where clients either received tickets that had the date and time they were to return to the center for services or stood in line to wait for services. Waiting took place first in the hot sun, then in a non- or poorly air conditioned building or under tents. It took clients 4–6 hr to find out whether they were eligible for services; most of that time was spent in line. Mental health volunteers worked the lines talking with clients, answering questions, giving toys to children, and providing drinks and snacks. We assisted clients in completing the required forms and even activated debit cards that provided clients with financial assistance. Within our varied roles, we had the opportunity to assess clients’ mental health needs, provide information, validate their experiences, process feelings, and offer support and encouragement. By being involved in all aspects of the client service center, we were readily accessible to clients, to relief workers who needed assis-
tance with clients, or to volunteers for their own personal needs. One of the most challenging aspects of being a mental health professional was comforting clients after they had been denied financial assistance. In the weeks immediately following the disaster, policies for providing financial assistance sometimes seemed to clients to be arbitrary, inconsistent, and nonuniform. Toward the end of October, however, Smith Scott and Haskett observed that there were few clients denied financial assistance and policies seemed to be straightforward and consistently applied.

Smith Scott and Haskett were assigned to assist for several days on emergency response vehicles (ERV) from which they provided mental health services as they helped to serve meals. An ERV could carry food and drinks for several hundred meals and was staffed by four or five volunteers, one of whom was a mental health professional. Residents as well as rescue workers were served by the ERV. As food was served, we mingled with the clients and listened to their experiences, informally assessed clients for mental health or other needs, and provided information about available services in their area. Smith Scott was assigned to work in an ERV that served St. Bernard Parish. The ERV in which Haskett served was driven the length of Plaquemines Parish, and ARC staff had to search for clients who were present (this area was deemed unsafe and access was restricted, so many residents were hiding from authorities). Meals were served to clients found huddled under tents, cleaning debris from their home sites, or dragging their shrimp and fishing boats from the waters. Many residents were Vietnamese, and their close community dispersed after the hurricanes. One of our roles was to assist in reconnecting isolated neighbors by providing information about other residents who had returned to the area.

Smith Scott was assigned for 1 day to accompany residents from the Ninth Ward when they were allowed back into their neighborhood for the first time. This occurred in organized bus rides to view the condition of the neighborhood. As in the other settings, listening to and acknowledging the experiences of these residents was the most frequently needed skill. Many residents came in family or neighborhood groups and provided social and emotional support for each other; these groups tended to seek practical information and news of recovery efforts more than emotional support.

Another setting in which we worked was ARC headquarters established in multiple locations throughout the Gulf Coast area to assess needs of residents and coordinate staff assignments. At headquarters, Haskett conducted exit interviews with volunteers who had completed their assignments and would be returning home. Although mental health volunteers were deployed for 2 weeks, all other volunteers made 3-week commitments; thus, those relief workers were particularly prone to physical and emotional fatigue. The exit interview provided workers with an opportunity for processing of their experience and an assessment of each person’s need for more intensive emotional support prior to or after returning home. Volunteers were encouraged to check in with their ARC chapter at home for further debriefing and to share their experiences with others who had been volunteers.

A final setting in which Nears worked was a client shelter in a school gymnasium. There were 20–40 homeless families living at the shelter. Some of these families consisted of three or four generations. Weeks into the disaster, clients still slept on cots and the only option for personal hygiene was gymnasium showers that were nonfunctional at times. Many shelter residents were afraid to take a shower because security and privacy were minimal. Nears was able to spend more time with each client in this setting than in many other settings. In addition to brief crisis counseling, he also addressed grief and trauma symptoms. Children were of particular concern; some of them had been in the shelter for nearly 8 weeks. Their homes and most of their belongings had been destroyed. Many had lost parents and/or other family members. They were out of touch with friends, and their routines had been terribly disrupted.

Client Characteristics and Mental Health Needs

Our observations of mental health and emotional states of clients are offered from the perspective of licensed professionals; we did not formally evaluate clients’ emotional health status. The full range of human emotion was evidenced, which was not surprising given research indicating that disasters are associated with diverse psychological outcomes (Norris et al., 2002). Many clients exhibited symptoms consistent with anxiety and/or grief and many cried as they provided personal information, recounted what happened to them, or described how they were coping with the psychological, emotional, and physical consequences of their experience. Other clients were solution focused and displayed minimal emotion as they set about solving immediate crises or assisting others. Clients stood in line in the heat and humidity for hours, holding babies and physically supporting elderly family members. For every person who complained about the long wait, however, there were many more residents who stated that standing in line was now their “job”—they were focused on obtaining services and getting their lives back on track. Many clients with chronic mental illness were destabilized because they had not taken their prescribed medications, and there were limited resources for refilling prescriptions. The crisis may have led some clients to avoid escape from the emotional pain and distress by using medication, drugs, or alcohol. Thus, evidence of substance use and abuse were not uncommon.

A prominent response of many clients was the expression of hope and faith. As much as the experience of trauma, anxiety, and grief were present, so was the resolution that things would work out or that God would take care of them. This ability to trust in the wisdom and resources of themselves or a higher power seemed an appropriate and even healthy response to tragedy. Religiousness was very common among clients as well as rescue workers who came to the area to assist in recovery. In spite of their many needs and what seemed like total disregard for the Gulf Coast residents at top levels of government, these survivors were incredibly resourceful, caring, and committed to helping one another. Clients were grateful for the limited support we could provide. One parent even offered to pay for meals provided by the ERV, and several clients returned after receiving services just to thank the volunteers again.

Toward the end of October in New Orleans, the limits to the amount of assistance clients would receive were beginning to be recognized. In many ways, clients felt somewhat paralyzed by the need to resolve immediate crises and still make long-term plans for recovery. Clients were in the position of having to make life-altering decisions, such as sending their children to live with relatives out of the area or relocating permanently, but did not have sufficient information or resources needed to make those deci-
sions. We assisted them in making small decisions with immediate positive outcomes to encourage them to regain control of their lives. Another issue that emerged at this time was the realization that the social relationships, supports, and indigenous networks of families and communities might not return as evacuated residents did not move back to their homes or when neighborhoods remained uninhabitable.

As stated previously, one of our primary roles was to monitor the emotional status of ARC relief workers. In the early years of DMH Services within the ARC, mental health professionals were sometimes viewed with skepticism as “shrinks” who would “analyze” the staff (Weaver, Dingman, Morgan, Hong, & North, 2000). We did not personally encounter staff resistance to our efforts to provide support and opportunities to process their experiences. Physical, psychological, and emotional fatigue were likely experienced by all relief workers at some point during their deployment. ARC workers also displayed symptoms of anxiety related to uncertainty about their particular role, changing policies and procedures, and the huge volume of daily work. Some described feeling physically and emotionally depleted or intensely sad after listening to the traumatic experiences of the clients (i.e., vicarious or secondary traumatization). Finally, we observed that a few relief workers appeared to have preexisting mental health conditions that hindered their ability to be fully effective and sometimes required that their volunteer service end; these cases were, however, very small in number.

Services We Provided

A model for provision of mental health services following large-scale catastrophic disasters is described by Young (2002), and we encourage readers to refer to this publication for guidance on provision of services in large group settings. Many aspects of the model were applicable to our experience. There seems to be a consensus in the literature that the evidence base for mental health assistance immediately following a disaster is limited. There is evidence, however, that providing assistance with basic needs and psychological first aid are likely the optimal intervention in the immediate aftermath of a disaster. We should note that controversy exists about the value of psychological debriefing (Litz, Bryant, & Adler, 2002); that controversy was not relevant to our work because it would not have been appropriate to conduct formal debriefing sessions. Mental health assistance immediately following a disaster is more often practical than psychological in nature. We were encouraged by the ARC to strictly limit our services to defusing and crisis interventions that focused on the immediate needs of the client. To intentionally engage in therapy was discouraged, given the brief deployment time of mental health professionals; limited information about the clients, staff, and community resources; large numbers of potential clients; and ethical guidelines for the practice of therapy or counseling. Furthermore, it was difficult, if not impossible, to follow-up because most residents had no permanent home, no phone, and no reliable transportation. In training, we were given guidelines for psychological first aid. We used many of the core actions of psychological first aid (National Child Traumatic Stress Network, 2005). These eight core actions are described below, accompanied by case illustrations.

Contact and Engagement

We monitored clients and relief workers, took notice of those who seemed to be in distress, and approached those individuals to begin a simple conversation. We introduced ourselves as ARC volunteers who were there specifically to listen to and assist people who might be feeling overwhelmed or need help solving immediate, short-term problems. Often, we quietly handed a tissue to a person who was crying and waited nearby in case they wanted to talk. We also responded to requests of relief workers to talk to clients in apparent distress. Because everyone was a potential “client,” we tried to make ourselves available to everyone we met during our stay in the area. For example, a young mother with several small children was sitting on the curb wiping sweat and tears from her face. We approached her and quietly offered a bottle of cold water. We engaged her children with crayons and a coloring book so the mother could have a moment to calm herself.

Safety and Comfort

As we monitored clients for evidence of emotional distress, we also took notice of physical needs. During conversations with clients, we provided information about safety of drinking water and where to locate mold removal supplies. We helped residents select food and cleaning supplies from the distribution areas and passed out masks and cleaning supplies from the ERVs. At the service centers, we escorted clients with physical needs to areas where they could sit while someone held their place in line. Because there were so many clients waiting for services, staff were reluctant to take breaks; we therefore monitored staff and strongly encouraged them to eat meals and take frequent short breaks.

Stabilization

Some clients exhibited very strong emotions or, in contrast, very restricted emotions or signs of disorientation. In this situation, we would talk to the person in a quiet place and try to meet their immediate need. For example, at one of the service centers a client who had been denied financial services because he did not have the required identification became very agitated. The financial aid volunteer, site supervisor, and mental health volunteer all helped him brainstorm alternative documentation that he might be able to locate to complete the application.

Information Gathering

One of our most frequent questions to clients was, “How can I help you today?” Having lost everything he owned, an elderly client had just returned to New Orleans without any cash. He qualified for financial assistance but because debit cards were no longer being issued, he was told he had to wait for a check to be mailed to him. He was confused, frustrated, and angry. His experience was validated and his coping strategies were discussed. Strategies that were effective were reinforced. In addition, places he could stay and how he could obtain immediate cash were brainstormed. Last, he was given contact information for organizations in the area that might be able to help and an information clearinghouse number.
Practical Assistance

Many of our clients had numerous pressing needs and appreciated having someone help them clarify which were most immediate and engage in problem solving with them. For example, one client had been lucky enough to have his trailer left unscathed by the hurricane, but now his brother and his brother’s children were living with him in the crowded trailer. From the client’s description, it appeared his brother was severely depressed and was not helping with the tasks of recovery and was not even taking care of his two children. The client was frustrated by his brother’s lack of assistance and his own inability to have any time or space for himself. Referrals for mental health resources for his brother were provided, and, through joint problem solving, a variety of plans were generated to help the client find some personal time.

Connection With Social Supports

Many of our clients had been separated from family, neighbors, and other typical community supports. One of our goals was to assist in the connection to available supports. Many people did this on their own while in line; they often found friends and neighbors they had not seen since the hurricane. The ARC also offered the Family Links Registry to help people find family members from whom they had become separated. Last, the establishment of a play area for children provided an opportunity for brief peer interactions.

Information on Coping

Ways to help clients cope might include normalizing reactions, providing reassurance, and offering different perspectives. For example, a client was crying and could not stop. She stated that she had a home and most of her needs were met but she was overwhelmed by the number of volunteers helping everyone and she was so grateful that she could not stop crying. Her reaction was normalized, she was assured that it was our honor to be able to help in the area, and she was given information about typical stress reactions. Another example involved a middle-aged female client who was crying uncontrollably. She had no family in the area and reported feeling depressed and hopeless. To add to her problems, the ARC had denied her application for funds. When approached, she repeatedly said “No one cares,” “People don’t care about other people anymore,” and “The world is cruel.” The mental health professional told her that everyone she saw with a red vest was a Red Cross volunteer who came to help her; at that moment she stopped crying. This client was given information for other available resources, and before she left the building she repeatedly said, “Thank you, you don’t realize how much this means to me.”

Linkage With Collaborative Services

The activity that we engaged in with almost every client was providing information about available resources. We had to be creative in identifying sources of help because there were so few reliable sources of assistance. Local churches were one of the most frequent referrals for a wide variety of clients needs. Government regulations often hindered our efforts to help clients, but our interactions with small local and/or larger private helping organizations (e.g., Salvation Army, organized religious groups) were highly successful. For example, we were able to refer residents to various religious organizations that provided clothing or assistance such as debris removal and tree cutting.

We found that throughout all of these core actions, listening was our primary method of helping clients. Through actively listening, we were normalizing and validating feelings. Often the stories clients told included life histories, as they placed the disaster in the context of their lives. Most clients we saw in the Gulf Coast region seemed to want to share their experience. From merchants in shops in the French Quarter to custodial staff at our hotels, all had emotional stories to share. In addition to allowing clients to share their experiences, we had to be open to clients’ silence. Often we simply held clients’ hands and let them cry. We tried to identify strengths and coping strategies in the personal tales of tragedy clients shared with us. We then discussed those with the clients with the hope that they would feel more empowered.

Lessons Learned and Impact on Us

One of the initial challenges we faced was our own apprehension and lack of confidence in our ability to respond to the incredible needs of the many survivors of this disaster. Because a large proportion of DMH workers were first-time volunteers, we were not alone in these feelings. Once we arrived in the area, we quickly realized that there was no time for this hesitation; instead, we needed to simply do the work at hand. Given our short-term deployment and the rapid turnover of mental health volunteers (new volunteers arrived daily), we had to quickly become experts.

We learned to rest when we could, and we took our day off when it became available. Physical and emotional fatigue was unavoidable. Most of our work took place outside in sweltering, humid weather or inside poorly ventilated buildings with questionable air quality. Grimmett was housed in a community center of a town near the client service center in which he worked. He took showers in a motel across the street from the community center where the ARC had leased two rooms, one for men and the other for women. The rest of us had accommodations in modest hotels. We were given 1 day off during the emotionally and physically intense 2-week period of service. Typical workdays lasted 10–12 hr, but in reality mental health workers were basically on-call all the time as we continued to process daily experiences with other volunteers well into the evening. “Compassion fatigue” (Gilbert, 2006) was evident, but close relationships that developed among volunteers did diffuse the negative effects of secondary trauma.

It could be reasonably predicted that the volunteer experience would affect individuals uniquely based on their past experiences, worldviews, and cultural backgrounds. The ARC established DHM services as a multidisciplinary group of mental health professionals (Weaver et al., 2000), and it was our experience that the mental health volunteers shared a collective sense of and belief in community. New alliances were established between diverse professionals (i.e., age, geographic origin, occupation, gender, race, and ethnicity) who had common values and professional goals. It was these relationships, developed among supportive peers, that affirmed and sustained the efforts and energy necessary to provide mental health services for clients as well as staff. We remain in contact with members of our volunteer groups, who continue to be a source of personal and professional support because of the meaningful connections formed through working together.
In training, we were told to “expect the unexpected and be flexible.” That proved to be the best advice we received. There were constantly changing circumstances, with daily (sometimes twice daily) changes in assignments and in staffing. Directions to locations were difficult to follow because road signs were missing and many roads could not be traveled. Haskett was given the following directions to find an assignment location: “When you get to the boat in the tree, turn left.” These circumstances required us to continuously use our best problem-solving skills and coping skills for reducing frustration. Patience was critical. We found humor to be effective in diffusing our frustration and lowering our stress; for example, one ARC volunteer stated, “We have found the disaster, and it is us!”

One of the biggest challenges to our work was that systems of mental health care and social services in the Gulf Coast region had been obliterated. Also unavailable were housing, transportation, sanitation, and good communication about the changing services that were available. Although medical professionals made heroic efforts to provide care during and after the hurricane (Frank, 2005), medical care was essentially nonexistent for all but immediately life-threatening situations (see Rosenbaum, 2006). Thus, we learned to live with discouragement stemming from our inability to make referrals to needed services for so many clients with serious needs. We learned to find satisfaction in simple accomplishments like providing food to hungry clients, connecting someone with services they needed, playing ball with children while they waited for their parents, and giving clients the correct answers to their questions.

This experience reaffirmed the importance of cultural awareness, sensitivity, and understanding. Cultural considerations have been noted as important by others who have provided DMH services in ethnically diverse regions (Dudley-Grant, Mendez, & Zinn, 2000), and guidelines for provision of DMH services to ethnic-minority individuals are provided in the literature (Norris & Alegra, 2006). Personal or formal knowledge of the social, cultural, and political experiences of culturally diverse groups among residents of New Orleans and other cities in the Gulf Coast region helped to establish rapport, trust, and credibility as a professional helper with clients. Consider how this statement by an ARC staff person may have affected the client to whom it was addressed: “If these are all your children, why do they each have different last names?” Of course there are many possible answers to this question. However, the cultural expectations of the staff person were such that all children within the same family should have the same last name. The cultural competence of the clinician, therefore, can facilitate, hinder, or jeopardize the therapeutic relationship. The experience of providing mental health services to survivors of Hurricane Katrina illustrated the need for continued personal and professional commitment to multiculturalism and social justice.

It was evident to our two African American male coauthors that their cultural familiarity, either assumed by the African American clients or actual, led to experiences with these clients and eventually to a perspective on the volunteer experience as a whole, which was fairly distinct from their Caucasian female peer volunteers. Some of the particular experiences that they had in common were (a) an acute and constant awareness of the disproportionate number of clients who were people of color relative to the volunteers and that poverty disproportionately affects people of color (Robinson, 2005); (b) racial identification with the African American clients that ignited a profound sense of empathy to their experiences, past and present, and enhanced sensitivity to their treatment by the ARC volunteers; (c) that some African American clients would ask certain questions and disclose certain information only to them (e.g., “What is the Red Cross really doing?” “Will the Red Cross actually be here for as long as they have stated?” and “That person did not help me, will you help me?”); and (d) victim-blaming communication from some (albeit, relatively few) relief workers to clients who displayed a lack of contextual understanding for the present reality of the client. The ethnicity of clients was less salient to our two Caucasian female coauthors, who were more struck by the extreme poverty and the lifelong severe stress of so many clients.

Last, this experience impacted our professional lives in the following ways: (a) created dialogue with colleagues about social responsibility and service, (b) enhanced clinical credibility with students, (b) raised student awareness of social issues, and (c) provided meaningful context and examples for classroom instruction and clinical supervision.

Closing Comments

One of the most profound concerns of the Gulf Coast area residents was whether there would be anyone who knew or cared about their ongoing struggles after the immediate crisis had passed and the media had left their communities. We shared those concerns as we left the area at the end of our 2 weeks and continue to be conscious of the enormous continuing needs of residents living in the Gulf Coast region and those who would like to return home. We hope others will join us as we continue to volunteer with the ARC and similar organizations and as we obtain further training in disaster preparedness.

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