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Swanson, David A et, al.

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Psychologists and Hurricane Katrina: Natural Disaster Response Through Training, Public Education, and Research

Stefan E. Schulenberg and Kirsten A. Dellinger
The University of Mississippi

Ann Marie K. Kinnell
University of Southern Mississippi

The purpose of this article was to describe a model of clinical/disaster psychology and illustrate how one psychologist applied training in the aftermath of Hurricane Katrina. The primary focus of the article relates to training graduate students of clinical psychology and assisting evacuees, public education and dissemination, and research. Psychologists may find themselves in similar positions when disasters occur in the future, and the linkage of research and theory with anecdotal accounts may provide mental health professionals with ideas regarding avenues of training to pursue and the various roles that may be served in times of disaster. Recommendations are offered to training programs with regard to infusing tenets of clinical/disaster psychology into their curriculum.

This article describes a variety of strategies that a psychologist may pursue to assist in the mental health response to natural disasters. It is primarily based on my perspective (SES) as an Assistant Professor in Clinical Psychology at The University of Mississippi who arrived at this position with specialized doctoral training in clinical/disaster psychology from The University of South Dakota’s Disaster Mental Health Institute (DMHI). I hope that my experiences will inform training programs and mental health professionals about how clinical/disaster training may be pursued and applied when a natural disaster occurs.

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Stefan E. Schulenberg received his doctorate in clinical psychology from The University of South Dakota, where he also specialized in clinical/disaster psychology through the University’s Disaster Mental Health Institute. Dr. Schulenberg is an assistant professor in the Department of Psychology at The University of Mississippi. His research interests include clinical/disaster psychology, psychological assessment, test validation, and logotherapy.

Kirsten A. Dellinger received her doctorate in sociology from the University of Texas at Austin. She is an associate professor of sociology in the Department of Sociology and Anthropology at The University of Mississippi. Her research interests include gender and sexuality in the workplace and qualitative methods.

Ann Marie K. Kinnell received her doctorate in sociology from Indiana University at Bloomington. She is an assistant professor of sociology in the Department of Anthropology and Sociology at the University of Southern Mississippi. Her current research examines the experience of a team of researchers implementing a survey in the context of a natural disaster.

David A. Swanson received his doctorate in sociology from the University of Hawaii, where he specialized in population studies and worked at the East West Population Institute. He is a professor of sociology in the Department of Sociology and Anthropology at The University of Mississippi. His research interests include applied demography, forecasting and estimation methods, and mortality differentials.

Mark V. Van Boening received his doctorate in Economics from the University of Arizona. He is an associate professor in the Department of Economics at The University of Mississippi and currently serves as the department chair. His research interests include applied microeconomics and experimental economics.

Richard G. Forgette earned his doctorate in political science from the University of Rochester. He is professor and chair of the Political Science Department at The University of Mississippi. His research interests include the U.S. Congress, legislative elections, public opinion, and public policy issues.

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Correspondence concerning this article should be addressed to Stefan E. Schulenberg, Department of Psychology, The University of Mississippi, University, Mississippi 38677. E-mail: sschulen@olemiss.edu

Training in Clinical/Disaster Psychology

Training programs and their directors should consider both formal and informal training opportunities for those interested in preparing to provide disaster assistance. Doctoral training in a formal program such as the Disaster Mental Health Institute (DMHI) at The University of South Dakota (http://usd.edu/dmhi/) is an important way to gain preparatory training. The DMHI offers a variety of training programs, including a doctoral Specialty Track in Clinical/Disaster Psychology, which is earned conjointly with the Clinical Training Program’s Ph.D. degree. Students take disaster-related coursework,
complete research (theses or dissertations) in a disaster-relevant area, and successfully complete a capstone exercise that entails addressing a disaster scenario while being evaluated by DMHI faculty and nationally recognized figures in clinical/disaster psychology. Psychologists who undergo such training are prepared to respond to a disaster and to serve as important “go-to” resource people for affected communities during these crises.

Yet, the opportunity for didactic training components in clinical/disaster mental health extends beyond the type of training offered by the DMHI. Other possibilities include training offered by professional psychological associations, both statewide and at the national level. For example, continuing education opportunities in disaster mental health response are frequently offered at the national convention of the American Psychological Association. Locally, the Mississippi Psychological Association’s (MPA) Disaster Response Network (DRN) has requested an educational track at each MPA conference to provide a continuing basis for training in clinical/disaster psychology, and the DRN of the MPA offered a recent 2-day retreat to provide mental health professionals with training opportunities (Martin, 2007). Psychologists with specialized training in disaster mental health may offer training to their colleagues in the wake of a disaster to provide a mental health response and to facilitate preparation for the next disaster.

A specific intervention that is an important aspect of training in clinical/disaster psychology is Psychological First Aid (PFA). PFA consists of many basic tenets; among them are establishing safety, providing accurate information, combating misinformation, avoiding false assurances, conveying hope, focusing on strengths and self-reliance, reestablishing social networks, focusing on the present, linking people with available resources, and facilitating problem solving (Reyes, 2006; Simonsen & Reyes, 2003; Vernberg & Varela, 2005; Zagurski, Bulling, & Chang, 2004). PFA is not therapy but, rather, a set of basic skills. Thus, disaster responders (e.g., trained paraprofessionals) may use PFA to relieve emotional suffering, as well as to help people come to terms with a sense of loss and access their internal resources (Jacobs & Meyer, 2006; Simonsen & Reyes, 2003). Psychologists also can offer this type of intervention to assist survivors of a disaster as part of their overall skill set and can train graduate students, interns, postdoctoral students, and community members in its use. A growing number of training modules are becoming available and from a variety of organizations, such as the National Center for PTSD and the American Red Cross (ARC). The ARC, in particular, offers several courses, including general courses such as Introduction to Disaster Services and Foundations of Disaster Mental Health, and courses targeting specific areas such as Psychological First Aid: Helping Others in Times of Stress (J. T. Kaster, personal communication, June 29, 2007; Koestler, 2006; Martin, 2007).

All training on disaster mental health should ultimately convey that how someone responds after a natural disaster is a complex interplay of factors. These factors include disaster history (how they have coped with trauma in the past), mental health history, exposure to trauma (length and intensity of the trauma), whether injuries were sustained, loss of friends or loved ones, extent of damage to home and/or community, use of positive coping skills, avoidance of negative coping skills, and internal psychological factors such as resilience and ability to discover meaning in their experiences (see Vernberg & Varela, 2005). The devastation from Hurricane Katrina, coupled with the prolonged disruption in social networks and routines, continues to be a source of stress for many survivors (see Sattler et al., 2002 and Vernberg & Varela, 2005). Although listening to a survivor’s story of his or her experience can be an important intervention in its own right (Dudley-Grant, Mendez, & Zinn, 2000), and opportunities to do so should be made available, not everyone wishes to share their experiences, and people should not be pressured to participate in a debriefing session (see Bryant & Harvey, 2000; Jacobs & Meyer, 2006; Young, Ruzek, Wong, Salzer, & Naturale, 2006). Potentially harmful pressures may be introduced under such circumstances.

Another important training point regarding disaster mental health includes highlighting the differences between working in the field and working in an office. Mental health contacts in the field are much more likely to be brief, with the psychologist “floating” to help others. Psychologists may also be involved in activities that are not typically associated with mental health, such as helping others to clear debris, serve food, and hand out water. As I learned while in training with the DMHI, these roles are great ways to check on people while simultaneously allowing them to know that mental health professionals are available, which may reduce the stigma related to psychological services or professionals. Work in the field requires a great deal of cooperation with other agencies, however. For this reason, training in disaster mental health should involve strategies for taking a community approach. Mental health-related services come from a variety of sources during times of disaster; thus, communication and the coordinating of services among agencies are essential.

Applying Clinical/Disaster Training in Response to Hurricane Katrina

Assisting Evacuees

How clinical/disaster training is applied will vary by the context of the disaster and the circumstances of the trained individual. By way of example, The University of Mississippi is located in Oxford, approximately 300 miles from the Gulf Coast. After Hurricane Katrina, Oxford experienced an influx of thousands of survivors. To accommodate these evacuees, a former Wal-Mart building (now owned by the University) was used as an ARC Resource Center. The joint efforts of the city; county; University; United Way; ARC; and local religious, business, and school organizations provided a variety of services at the ARC Center, including a canteen (assisted by local church and restaurant groups); medical care through a local hospital; a lounge; information and assistance about jobs, housing, and educational opportunities; financial assistance; and mental health services. The ARC Resource Center addressed approximately 1,479 cases (individuals and families representing about 4,900 to 5,000 people), with $1,085,181 distributed in the form of vouchers and client assistance cards, and was in operation from approximately September 6, 2005, to September 19, 2005 (B. Howell, personal communication, August 3, 2006).

Students and faculty in the doctoral Clinical Training Program in the Department of Psychology at The University of Mississippi became involved in Oxford’s relief efforts. Maintaining a mental health presence at the Center provided the people seeking services with assistance, and for people not seeking services, it served the purpose of letting them know that help was available if they
wanted it. To facilitate this process, a colleague and I presented a training session in early September 2005 to graduate students on how to work with survivors of a natural disaster. Graduate student participants were those who had developed effective therapeutic skills through coursework, supervised work in the Department’s Psychological Services Center, and practicum placements (effectiveness was determined via progress in the Clinical Training Program). Information conveyed in our training consisted of the type alluded to above (e.g., fundamentals of PFA, responses to natural disasters). Graduate students subsequently provided assistance at the Oxford ARC Resource Center, with psychological supervision/consultation provided by faculty (clinical psychologists) in the Department’s Clinical Training Program.

Public Education and Dissemination

Dissemination of mental health information is important after a disaster for many reasons. Disasters often result in miscommunication and the perpetuation of information that may later turn out to be false. Questions about stress, anxiety, and mental health among the general population are heightened after a major disaster. The media tend to cover these issues more frequently during a disaster, and psychologists are often sought as resources. In these cases, psychologists can assist in a disaster situation by clearly and accurately conveying relevant and empirically supported mental health information to a variety of audiences.

Along these lines, after Hurricane Katrina, I communicated during a period of months with The University of Mississippi school newspaper and other news outlets (e.g., other newspaper sources, MS Public Broadcasting) to provide information about typical and maladaptive (e.g., increased drug/alcohol use) responses to natural disasters, the potential benefits and applicability of mental health services and where mental health services may be found, and how cues, anniversaries, and increased media coverage may function as reminders that can be problematic for some. The nature of the information conveyed depends on the context of the disaster, available resources, and the time of the interview (e.g., immediately after a disaster, it is most important to address essential needs such as food, water, clothing, shelter, whereabouts of family members, and maladaptive responses).

In working with the media, it is important to make certain that your statements are not taken out of context. It does not hurt to ask for a list of questions in advance of an interview, such as the case of a newspaper interview, so that you can prepare written responses beforehand. In face-to-face interviews, take the time to understand the questions that are being asked; to say what you mean; and to communicate responses in clear, jargon-free terms that people without training in psychology will understand. Pre-viewing how interview material will be used helps to avoid the problem of reporters or editors using information to make points that were not intended. In one case, I arranged to review a copy of the quotes I gave about Hurricane Katrina before their publication in a newspaper. When I saw a draft of the article, I discovered that my quotes were taken out of context and were applied to another disaster that occurred under much different circumstances. The problem was eventually corrected before the article was published. For such reasons, incorporating recommendations on working with media outlets in training would be helpful to the graduate students, interns, and those in postdoctoral positions who are interested in disaster mental health (see Farberman, 2003 and Tumlin, 2006 for suggestions for psychologists on working with the media).

Psychologists may also help their colleagues by providing information through print (newsletters) and/or electronic (list serve) modalities, and by facilitating further education and discussion via conference presentations. For example, I contacted the MPA to offer assistance with the mental health response to Hurricane Katrina. This contact evolved into a coauthored article on PFA that was distributed through the MPA’s list serve before being published in the Association newsletter (Schulenberg & Kaster, 2005). The article contained recommendations for psychologists who were providing services to people affected by Hurricane Katrina and suggestions on how psychologists could be better prepared for future natural disasters through additional training. Presentations may also be of assistance in some circumstances. For instance, in response to a request based on the newsletter article, my coauthor and I gave a formal presentation on PFA at the MPA 2006 conference. I also gave a presentation at the Mississippi Academy of Sciences 2006 conference on mental health issues in conducting research with people affected by natural disasters.

Thus, even under circumstances in which psychologists are unable to provide direct, on-site assistance, they can offer help to their colleagues who are able to do so, and offering presentations stimulates interest in clinical/disaster psychology and the subsequent growth of the field. Depending on the avenue of assistance chosen and the context, psychologists may be of help in the immediate aftermath of disasters (e.g., some mental health professionals have developed manuals for professionals and coloring books and other educational materials for children), as well as in the ongoing recovery process (e.g., disseminating information regarding traumatic cues and the impact of anniversary dates).

Assisting in Research Efforts

Psychologists also can contribute in the aftermath of a disaster through research. Conducting research that evaluates the efficacy of psychologists’ attempts to provide assistance is one way to help (Dudley-Grant et al., 2000; Young et al., 2006), and more research is needed to better understand the effectiveness of training (Young et al., 2006). For example, take PFA. Although Jacobs and Meyer offer some guidance as to future research, there is much we do not know about the effectiveness of PFA, and it remains an area where research is especially welcome (Halpern & Tramontin, 2007; Jacobs & Meyer, 2006). How much training is necessary to maximize the transition of PFA skills outside the training environment and into the field? The clarification and systematic study of PFA are of paramount importance if disaster training and relief efforts are to continue to improve.

Conducting research in a postdisaster environment is a methodologically complex enterprise. Psychologists can serve an important role as consultants to research teams who will be having direct contact with survivors of a disaster. They can assist by training other researchers what to expect in the field, how to treat participants ethically, and how to measure psychological phenomena reliably. As one example, I served as the consulting psychologist for a team of interdisciplinary researchers studying the impact of social networks on individuals’ post-Hurricane recovery in Harrison and Hancock counties (the two hardest-hit counties in Mississippi), 4 months after Katrina. I provided a training session in one
of the only operational hotels in Biloxi, Mississippi, to approximately 20 survey team members before data collection in January 2006.

The intent of the training was to provide essential preparation for what team members may expect in the field, both in terms of interacting with residents and in dealing with their own reactions to working in a disaster-affected area. This training experience was consistent with the DMHI model, pointing to the importance of public speaking to disaster mental health work and being able to effectively work with individuals with a variety of backgrounds and under unusual conditions. With the aforementioned goal of preparing team members so they would have a better understanding of disaster-relevant issues (e.g., range of responses people experience in relationship to a disaster, information about the survey environment), I assembled and discussed a packet of information that included relevant do’s and don’ts of data collection/survey field work, stress reactions in response to natural disasters, and mental health referral information for survey respondents (and for the surveyors themselves, if needed). The importance of self-care and maintaining general well-being was emphasized, considering the stressful data-collection context. Pertinent psychoeducational reading materials that were discussed included references by Fullerton and Ursano (2005) and Norris (2005), as well as educational handouts from the DMHI.

Another challenge facing researchers in a disaster context is soliciting the participation of a stressed population in an ethical manner. Psychologists can work closely with institutional research boards so that research projects conducted in a postdisaster context meet the ethical standards necessary to protect human participants. Another task I performed with the interdisciplinary research team involved gathering mental health referral information for those affected by Hurricane Katrina to be distributed with the major survey instrument. This necessitated contacting several agencies, including the ARC, the Mississippi Department of Mental Health, and Project Recovery (a program associated with the Mississippi Department of Mental Health that was created to help people cope with the effects of Hurricane Katrina). I discussed the research team’s objectives with personnel from each resource to open a dialogue and to verify the accuracy of the information offered to the research team.

Because research projects often form quickly in the aftermath of a natural disaster, they present challenges for researchers working to develop cogent research questions and efficacious research designs, as well as in the selection of appropriate psychometric tools to aid investigations. In addition to dealing with logistical problems working with a damaged infrastructure and ethical considerations working with disaster-affected populations (Norris, Galea, Friedman, & Watson, 2006), psychologists may find themselves in a position to provide researchers with consultation on research design to ensure that relevant and psychometrically sound assessment tools are used. Training in test construction can be of particular importance in clinical/disaster psychology. In this respect, I aided the interdisciplinary research team by assisting in the review of the survey they were designing with regard to item inclusion, wording, and response format, and by reviewing the literature and consulting with several agencies (e.g., the National Center for PTSD) for a psychometrically sound measure of Posttraumatic Stress Disorder (PTSD). The survey instrument on which I consulted included attitudinal, experiential, demographic, socioeconomic, and social measures of personal relief and perceptions of recovery. With regard to a measure of PTSD, the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993; Blanchard, Jones-Alexander, Buckley, & Forneris, 1996), a brief and sound measure of PTSD symptom severity (Norris & Hamblen, 2004; Orsillo, 2001), was selected, with the PCL-S form of primary interest given that it prompts responses toward a specific event.

Preparation for the Next Disaster: Recommendations for Psychologists

Planning, coordination, communication, organization, problem solving, and decision making are but a few of the skills needed in developing an effective disaster response system. Whether man made or natural, when disaster strikes, the best of plans seems to go awry. Responding agencies tend to experience internal organizational problems and oftentimes are not prepared to interface effectively with each other in coordinating emergency response and disaster services. The magnitude of the disaster is usually unexpected and has the potential to wreak havoc on infrastructures. Advanced planning and coordination within and among agencies are imperative. Developing a large volunteer reserve, with appropriate training in various aspects of disaster relief, is also of great importance. To effectively prepare for the next disaster, psychologists should identify themselves with a recognized disaster response organization, complete disaster mental health training and other required training, and gain experience in the field.

When entering a disaster area to provide mental health or other relief services, the psychologist is required to be identified with some recognized disaster-relief organization. Working with agencies such as the ARC or the Department of Health and Human Services is particularly important for mental health professionals to establish credibility in the provision of services and a larger structure to use their strengths to the fullest and to coordinate mental health efforts (G. A. Jacobs, personal communication, September 14, 2005). It is also important to receive training and to establish a relationship with a relief agency before the chaos of disaster because relief agency personnel tend to receive many offers of mental health assistance after a disaster, and with the difficulty inherent in sifting through offers and coordinating services once a disaster has occurred, they tend to rely on relationships that have been previously cultivated (Vernberg & Varela, 2005; Young et al., 2006). Agencies requiring background checks or additional training (e.g., the ARC Foundations of Disaster Mental Health course) should be identified and any requirements completed. In other words, the time to prepare for the next disaster is now, and training is the key to assembling an effective mental health response.

We may believe that we are prepared to go into a disaster area and provide mental health services. However, this is not always true. Volunteering with local ARC chapters provides opportunities to experience crisis situations on a smaller scale (fires, industrial accidents). Furthermore, psychologists can also volunteer through the ARC Disaster Services Human Resources System, which allows for out-of-state and out-of-country deployment, and additional opportunities to become involved may be available through state Disaster Response Networks (Koestler, 2006).
Recommendations for Clinical Training Programs and Training Directors

Clinical training programs and training directors may use several strategies to foster educational opportunities in clinical/disaster psychology for their trainees. For instance, colloquia on particular topics relating to the field of clinical/disaster psychology (e.g., PFA) could be offered to introduce trainees to the major concepts and methods of disaster psychology, sensitize them to the complex issues in the field, and alert them to opportunities for further training. Those conducting a colloquium could be trained psychologists, or instructors from the ARC (this being one way that clinical training programs could foster relationships with disaster relief agencies, enhancing training and preparation for the next disaster).

To be effective as a psychologist in responding to a natural disaster such as Hurricane Katrina, it is imperative to have strong generalist training, coupled with specialized education in disaster-related mental health issues. In addition to honing the core psychosocial skills of trainees, training programs may also offer advanced seminars in clinical/disaster psychology focusing on such areas as:

1. A historical overview of the field
2. Roles of mental health professionals in disaster response
3. Typical and maladaptive responses to various kinds of disasters
4. Vulnerable populations, such as children, older people, and those with mental illness
5. Crisis intervention strategies (short-term) and treatment approaches (long-term) with an empirical foundation
6. Ethical, rural/community, multicultural, and cross-cultural/international psychology issues as pertains to clinical/disaster psychology
7. Emphasis on aiding first responders, who are vulnerable to the emotional strain of working under intensive conditions (Halpern & Tramontin, 2006; Sternberg, 2006)
8. Guidelines for working with the media; public speaking and presentation skills
9. Research needs and issues in conducting research with disaster-affected populations

Such courses are consistent with the DMHI model. Through these kinds of educational opportunities, mental health professionals in training programs will be better prepared for the rigors of disaster field work and, once licensed, will be better able to work effectively with agencies in a culturally sensitive and multidisciplinary fashion.

Summary

The purpose of this article was to integrate theory and research with anecdotal accounts to highlight a variety of ways that psychologists can help in the mental health response to natural disasters. A university-based training curriculum was described, as well as how such a curriculum may be brought to bear in the aftermath of a natural disaster such as Hurricane Katrina. Particular attention was paid to training graduate students and helping evacuees, public education and dissemination, and assisting in research efforts. Psychologists may find themselves in similar positions when future disasters occur, and those interested in learning more are encouraged to contact their state Disaster Response Network or relief agencies, such as their local chapter of the ARC. Finally, suggestions for incorporating clinical/disaster psychology in training programs was outlined in order to facilitate the development of requisite skills in a growing number of mental health professionals nationwide.

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