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Making Disaster Response "Real" for Students: Corresponding with Mental Health Professionals after Hurricane Katrina

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In the summer of 1993 the Midwest experienced unprecedented flooding. That fall, I had my Community Psychology students correspond with residents who were coping with this disaster. I wrote newspaper editors of newspapers in the affected area offering the chance for flood victims to share their stories with my students and to get a personal response. Through several dozen letters we received, my students learned the degree to which disaster response theories capture reality.

When Hurricane Katrina occurred in late August, 2005, a similar project seemed valuable for this year's Community Psychology class. However, Katrina was so enormous and disruptive we did not know how to contact affected individuals. It seemed less intrusive to correspond with the mental health professionals helping in the disaster rather than with those in need of their help. We waited a while before making contact, recognizing that professionals had more important work to do than answer students' questions. After consulting with Jim Dalton, I began to identify those on the mental health front lines. The students and I decided we would learn more about a community's response if we focused on a limited geographic area such as Gulfport, MS, rather than a large one like New Orleans.

Corresponding with Professionals in Gulfport

After several false starts, I reached the director of the mental health center in Gulfport who referred me to Andrew Klatte, the leader of the Indiana mental health disaster team that worked in support of the Mississippi Department of Mental Health so that Gulfport's mental health infrastructure could be reestablished. In our conversation, Mr. Klatte expressed interest in the project. The class and I developed a set of questions and emailed them to him. At roughly the same time, I learned through the Internet that Dr. Kathleen Reyntjens, a psychologist working at the Veterans Administration (VA) Hospital in Gulfport, was a trauma specialist. I emailed her and she, too, was willing to answer our questions. We emailed a list of nine questions on October 21, 2005.

Our initial questions for professionals asked about their general observations of the hurricane's impact, how they and other professionals responded, and the community's resilience. To illustrate, the first set of questions were these: "What was the level of disruption caused by Hurricane Katrina? What are community's intrinsic resources and strengths?" We also wanted to know about the intended and unintended consequences of

the crisis and helping. For example, we asked, "What services are being directed toward the mental health needs of children? Toward first responders?" "Have any of the relief efforts had the unintentional effect of causing more stress?" "Has any aspect of the hurricane been a blessing in disguise? For instance, has it helped people live a simpler lifestyle or brought people together who normally would not?"

The answers we received from Dr. Reyntjens on November 2 were illuminating (Dr. Reyntjens' remarks reflect her own opinions and do not necessarily represent those of the Veterans Administration). For example, she told us that the response of religious congregations "was overwhelming and courageous as they drove from street to street, even before other relief agencies," a testament to the importance of religious institutions in communities. She indicated that in the first counseling sessions after the disaster, clients told such harrowing stories as finding a passing refrigerator to climb into or tying themselves to trees to avoid drowning. She explained how professionals helped one another through the crisis. "We have all been open with one another, asking for feedback if we seem to be out of sorts or making poor decisions." Because a quarter to a third of the VA employees had "lost their homes and a high percentage of the remainder had severe and life-disrupting damage and losses," the VA administration "advanced every employee 15 days of additional leave to tend to hurricane-related matters." Her answers taught my students how Gulfport responded to the crisis, what VA therapists did to help their clients, and how organizational policy supported the work.

Shortly after this, Andrew Klatte offered fascinating insights into the turf conflicts that sometimes erupted among agencies and the heroic efforts of the local mental health center and the teams of mental health professionals who came into Gulfport providing immediate help. The local center staff "established...a morning meeting in order to coordinate who was doing what. They had many of their staff going to shelters in order to find their clients." Their efforts helped the infrastructure come back. He also described the need for cultural sensitivity since Gulfport has a large Vietnamese community. Health and mental health clinics could not have been set up "without the help of the local Vietnamese leadership." And later, when people in the Vietnamese community feared engagement with the Federal Emergency Management Agency (FEMA), locals were hired to team up with crisis counselors to explain the advantages of applying to FEMA.

The students developed a second set of questions for Dr. Reyntjens. We wondered how the nature of helping and recovery had changed in the weeks since the initial aftermath. Were symptoms of PTSD becoming evident? Were there signs that some responded to the crisis by becoming stronger or had despair sapped initial optimism? How had people responded to FEMA?

Dr. Reyntjens' response to the second set of questions gave us a clear sense of how recovery changes over time. Writing 14 weeks after the storm, she said, "What we are seeing now is more grief and depression, more anger, more substance abuse, less tolerance, more hypomanic behaviors (in those who are not normally that way), more medication required." She, too, described heroic efforts: teams from religious congregations showed up at people's homes and cleared debris. She also reported increased flashbacks among her Vietnam-era PTSD clients: "Some reacted to the helicopters flying overhead, others to the smells reminiscent of dead bodies... each patient seemed to have their own memories triggered in some way or another." All in all,

depression and the magnitude of the recovery effort had taken hold; more people were angry and frustrated with FEMA, the Red Cross, and life in general.

Conclusion

The Gulfport project made links for my students that rarely occur in a regular Community Psychology class. For instance, we always study the Dohrenwend model. This semester allowed them to see concrete examples of how individuals and communities respond to stressful events. The anecdotes we were told gave us a glimpse of what happens over the long haul of recovery. We are indebted to Dr. Reyntjens and Mr. Klatte for sharing their knowledge; we learned a great deal. Students evaluated the experience positively, citing the insights they gained into the strengths and weakness of the community's response.

This kind of behind-the-scenes look at community psychology could be useful in situations other than disasters. For example, it might be useful for students to learn what it takes to develop, evaluate, and maintain a prevention program; this could be done by emailing the directors of model programs. To my knowledge, only a few sources (Jason, Keys, Suarez-Balcazar, Taylor, & Davis, 2004; Munoz, Snowden, and Kelly, 1979) offer insight into the challenges community intervention researchers face. Establishing a correspondence with program developers and evaluators could be an effective way to engage our students in community psychology.

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