# In the Wake of Hurricane Katrina

## Delivering Crisis Mental Health Services to Host Communities

### Aretha Faye Marbley

### Journal Entries

*August 26, 2005*

Today, for most of the morning, I sat glued to the television, like millions of Americans in disbelief as I watched thousands of people who look just like me and my folk, stranded in dire stress at the Superdome in New Orleans. I could not believe my eyes; I could not believe this was happening in America in the year 2005.

*September 1, 2005*

This has been a heavy and emotionally draining week for me. I have left several messages with the local Red Cross about volunteering and maybe organizing some of our clinical students to provide mental health services to the evacuees and have heard nothing back. I keep remembering the events from last Sunday morning; I watch on the local news the hundreds of evacuees, a majority of them Black and New Orleanians, deboarding airplanes.

The news cameras were focused on each evacuee as he or she stepped off the plane, surrounded by our City's finest, the police. The evacuees appeared weary and tired and were seemingly surprised to see so many warm smiles and gestures. Lots of people showed up to greet, welcome, and help the victims of Hurricane Katrina.

After leaving the airplanes, the evacuees boarded the city buses where they were carted off to their temporary shelter, our closed United States Air Force base. Once again, they were greeted by hundreds of warm smiles and enthusiastic helping hands, and once again, the camera

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was there to capture it. I looked to see if I could see any familiar faces, either evacuees or volunteers. And I did recognize colleagues, friends, and students. It was a good feeling.

*September 6, 2005*

I began my volunteering effort at 8am this past Sunday morning, a week after the excitement of having company in our city settled down. When I checked in, I found hundreds of individuals still struggling with what all of this meant, including challenging their fundamental view of the world, of their faith, and God, as well as seeing this place as safe.

Although most of the volunteers had left, there were still plenty of medical, mental health, technical, and concerned citizens of our community and surrounding communities eager to help. The Red Cross, working closely with local property owners and agencies, had less than a week left to either transport the evacuees back to Louisiana, with relatives and friends, or find them permanent housing, the last being the option the majority of the evacuees had chosen.

Not knowing the city and coming from a city with high crime neighborhoods, the evacuees also had some concerns about the safety and the character of the communities where they would be living. As an African American migrant to the city, I knew of the racial issues present as well as the communities' historical resistance to racial, ethnic, and class integration.

According to most of the people that I spoke with, it seemed that no one broached the subject of race. One lady told me that not one of the volunteers wanted to talk to them about Black folks' experiences in Texas and Texas cities, and she didn't feel comfortable bringing it up. I'm thinking that the discomfort could have been due

in part because the volunteers, medical and mental health professionals included, didn't think it was important, weren't comfortable talking about it, thought it was a nonissue because the majority of volunteers were non-Blacks, or didn't want to make the evacuees uncomfortable. My real gut feeling is that it was the case of the dinosaur in the living room.

I felt comfortable talking about what it meant to be a person of color in our city; however, I didn't want to paint a negative picture of a truly generous and loving community of good people. Therefore, by relating back to the reality of racism and continual existence not only in our country but in their hometown, I was able to process some of their concerns and fears regarding confronting racism, and to a lesser degree, classism as African-American people relocating to Texas and to Texas towns. All in all, I spoke with about 30 evacuees; some were depressed and desperately longing to go home, and others were eagerly looking forward to new beginnings in our city. The evacuees expressed much gratitude to the people for welcoming them into our community.

Just sitting here, reflecting on the conversations about racism and relocation with the evacuees, I suddenly realize that the missing component in comprehensive crisis counseling with these evacuees is addressing the mental health of communities. More specifically, we need a way to gauge the host communities' solidity and stability over time as a result of the relocating of people who are ethnically, culturally, and racially different from the existing community members for the sake of both groups, the evacuees and the old community members.

*September 17, 2005*

I am feeling so frustrated and having a hard time sorting through the circumstances, especially from a mental health perspective, surrounding Hurricane Katrina. We don't seem to know what to do, and it is too complicated, convoluted, and overwhelming for one person to sort through. Earlier today, I thought to myself, as professionals, medical and mental health providers, and educators, from many disciplines; together we know something about almost any situation. We know about diversity of people medically, physiologically, psychologically, biologically, sociologically, anthropologically, historically, linguistically, educationally, economically, religiously, domestically, and internationally over societies, generations, and civilizations.

We have theories, therapies, theorems, techniques, strategies, treatment plans, and models for emergency and crisis situations out the wazoo. From the social psychologists, we know about helping, why people help or not help; we even know when and under what conditions people stop helping. We know this from local, state, national, international, and global perspectives. Thus, it seems unfair to me for all involved not to understand the effects of bringing new people into the host communities and not providing mental health services that we know would make the transitions livable for both new and old community members and institutions within the communities.

In fact, armed with so much knowledge, it seems not only unethical and inexcusable, but unconscionable, be it unwittingly or unknowingly, for professional people to place the evacuees, who have already been traumatized, in environments without the proper tools or knowledge in an environment to be distressed unnecessarily. Damn. Rather, it makes more sense to me that as professionals, in all our great and vast wisdom and education, we combine our shared multidisciplinary knowledge in order to make this marriage between the evacuees and their communities work. Tonight, I am so damned frustrated trying to explain this simple concept to so many people that I am cursing . . .

*October 9, 2005*

Today, I was told that evacuees living in one of the apartment complexes in a predominantly White community in town received a letter from their landlord/real estate agency that stated: "Gathering in crowds of more than four or five, talking loud, and loud music are not allowed on the premises." To the Black evacuee tenants, this notice reeked of racism and treating them like children. As a result of being chastised, they were insulted, surprised, angered, and hurt by those few words. Reflecting on those same words, I too felt insulted—the words in the letter stung my ego, pride, and my soul, and for the rest of the day rendered me speechless.

On Friday, I was about to give a brief talk to a group about *vicarious trauma* or *compassion fatigue* and the necessity of mental health clinicians assessing and monitoring its effect on the volunteers and communities working with trauma victims. And there, out of the blue, I found myself overwhelmed with just that.

In speaking to the group of mental health professionals about my volunteer work with Katrina evacuees, I suddenly found myself choked up with emotions, unable to stand, literally and unexpectedly traumatized. It took me a few minutes to gather my thoughts and allay my intense emotions. How ironic, in the midst of talking about compassion fatigue and secondary trauma, there I was, barely a month later, reliving the experiences of seeing all those thousands of people, Black and poor, trapped without food or water, caged-in like animals, in dire distress, and begging and pleading for help.

### Coping with Hurricane Katrina

Throughout the country and especially in Texas, local communities opened their arms to hurricane Katrina evacuees. Like the federal government, emergency health and mental health entities were unprepared for the massive numbers of people needing assistance. Mental health professionals, though armed with a wealth of crisis intervention information, weren't equipped with skills for either anticipating or assessing the effects of the relocation of evacuees into local communities on the mental health of the humanitarian host communities.

Many Gulf Coasters lost their lives, loved ones, homes, jobs, businesses, and suffered through inhumane conditions for days without food and water, surrounded by death, destruction, and violence when Hurricane Katrina struck in late August of 2005. Hurricane Katrina's devastation changed the lives of millions of people who live along the Gulf Coast as well as the multimillions of people throughout the country and the world who watched it happen. Yet, the response to the disaster was as unprecedented as the widespread devastation of the hurricane.

Likewise, the generosity of people was unprecedented; individuals, the media, celebrities, businessmen, states, cities, towns, the international world, community organizations, faith-based institutions, public schools, colleges and universities all rallied around rescuing the refugees. As a resident of Texas, I was enormously proud to see Texas boldly leading the evacuation effort by taking in over a quarter-million Katrina evacuees.

Yet, despite good intentions and in spite of the massive efforts to get people to safety with food, water, and crisis intervention counseling, communities were stressed and strained. In Texas, government officials and local governments needed money to provide basic health and mental-health care for evacuees, but also accommodations for the new students placed in Texas' schools. As a consequence of the rapid depletion of the state's resources, responding to the disaster took its toll on Texas and Texas communities.

Not having a well-thought-out exit plan for the evacuees forced Texas to switch from an emergency relief mode to one of concern about the effect of the long-term stress of providing indefinite care for over 230,000 people and the strain that would cause to the state's economy and resources. In voicing their worry that Texas would be stuck with huge bills as a result of accommodating the evacuees, two state senators emphatically stated that the influx of people was draining the resources of Texas communities (Pergram, 2005).

Documented studies have addressed the emotional trauma from disasters like Hurricane Katrina and what can be done to help the victims cope (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, et al., 1990; Langstaff & Christie, 2000; Shelby & Tredinnick, 1995; Soloman, Oppenheimer, & Noy, 1986; Weber, Bass, & Yep, 2005). For Katrina victims and the people and communities responding to the disaster, the psychological implications are yet unknown, but are guaranteed to be tremendous, now and in the months and years to come. Therefore, incorporating mental health services for individuals and communities that address race, class, and culture is a critical component of comprehensive crisis mental health services to the evacuees, their families, and the communities that housed them. This article introduces a crisis mental health service delivery model for addressing the devas-

tating effects of disasters, like Katrina, on communities, specifically humanitarian host communities, a model that address inherent cultural issues.

### Emergency Responses

Selflessly and without delay, people all over Texas dug deep into their pockets, opened up the doors to their cities and even their homes, and with rolled-up sleeves turned out in droves to volunteer in order to aid the people devastated by Hurricane Katrina. Texas Governor Rick Perry (2005) stated that, "Texans' generosity and compassion is as large as our great state" as he announced the establishment of the Texas Disaster Relief Fund to help provide immediate assistance to evacuees of the Gulf Coast.

As a result of people's response, the Red Cross was inundated with new volunteers from all walks of life and professions; this included a large number of health and mental health workers who were ready, willing, and able to help in all ways possible in the face of overwhelming events. Many emergency organizations were involved in rescue efforts from governmental entities (Federal Emergency Management Agency [FEMA]), to private agencies. Organizations such as Feed the Children and the American Red Cross did a commendable job in organizing resources and manpower in the face of such urgency and an overwhelming number of people in need. Food, medical treatment, and shelter weren't all that refugees of Hurricane Katrina required; rather, many of the victims also needed mental-health crisis intervention.

According to one newspaper, "Hurricane evacuees are understandably stressed: In any disaster, you run into emotions, the bigger the disaster, and the stronger the emotions" (Wagner, 2005). Government officials, state and local, needed money to not only provide mental health care for evacuees, but also to accommodate new students in Texas schools. From a mental health response to the disaster, professionals from mental health associations such as the American Counseling Association, American Psychological Association, and the National Association of Social Workers disaster response networks headed to affected areas along the Gulf Coast to assist the Red Cross in providing hurricane survivors with counseling and other services, while the mental health practitioners, like myself, readily volunteered in local communities.

### What about Community Mental Health?

A few days after the emergency evacuation plan to rescue people stranded in New Orleans and other parts of the Gulf Coast, refugees were evacuated to Texas, primarily Houston. This meant that more than a quarter of a million refugees landed on the yard, porch, and doorstep of communities in Texas; a disproportionally high number of them were African Americans. Ultimately, to not consider the enormous impact of the relocation of tens of thousands of evacuees on children, families, and communities is one means of losing ground in providing for the welfare of the evacuees.

The Red Cross webpage offered disaster educational materials, training, and complete, flexible programs such as Community First Aid and Safety that help a community stay prepared for virtually any life-threatening situation. The Community First Aid and Safety program is geared to help community members recognize and respond to emergencies including shock, cardiac, and breathing emergencies for adults, children, and infants; heat and cold emergencies, sudden illnesses and poisoning, and first aid for everything from cuts and scrapes to muscle, bone, and joint injuries.

There were tons of materials regarding helping communities prepare for a disaster, but nothing about the vicarious trauma communities may experience as a result of providing emergency and short-term care to victims of disasters. Nor was there any information or support on providing mental health services directly to communities, as opposed to individuals within the community, who are providing shelter and housing for a large number of victims. Nevertheless, at the community level, mental health must be broadly defined, the value of many types of data must be recognized, and a change in perspective from individual-based thinking to community-based thinking is required.

### Theoretical Frameworks: Approaches That Actively Engage the Community

There are very few, if any, theoretical models unique to understanding the nature and the complexity of trauma effects on the mental health of communities. Therefore, I offer a combination of community-based and neighborhood organizing and compassion fatigue (secondary trauma) stress frameworks as theoretical lenses and to

organize the discussion of the effects of Katrina on humanitarian host communities, especially the aftermath effects of being intimately involved in rescue efforts.

Although primary posttraumatic and secondary trauma stress data are typically applied to individuals, the tenets apply to community mental health counseling where communities were directly or circuitously involved in traumatic situations. According to Zimering, Munroe, & Gulliver (2003), primary posttraumatic stress disorder refers to an individual who experienced, witnessed, or was confronted with a traumatic event and responded with intense fear, helplessness, or horror. Either intentional traumas such as combat, sexual assault, terrorism, and mass violence or unintentional traumas such as natural disasters and accidents may cause a posttraumatic stress condition.

*Compassion fatigue,* also known as vicarious traumatization or secondary trauma, on the other hand, is indirect exposure to trauma through a firsthand account or narrative of a traumatic event. The vivid recounting of trauma by the subsequent cognitive or emotional representation of that event may result in a set of symptoms and reactions that parallel secondary traumatization (Figley, 1995; Gentry, 2005; Zimering, Munroe, & Gulliver, 2003). People experiencing compassion fatigue often respond with a set of symptoms and reactions that parallel PTSD (e.g., re-experiencing, avoidance, and hyperarousal).

Therefore, from a community mental health lens, Gulf Coast communities directly hit by hurricane Katrina are experiencing primary posttraumatic stress. In contrast, humanitarian host communities that responded to the crisis by accepting Katrina evacuees, regardless of providing short-term emergency shelter or permanent housing, are vulnerable and at risk for compassion fatigue or secondary trauma. This means that, like people, communities respond with issues related to safety, trust, esteem, intimacy, and control and therefore require crisis mental health services.

The other theoretical framework, community-based organizing, is a process through which communities are helped to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set. Organizing efforts often fail because they are reactive, because they lack thoughtful strategies, and because they employ the wrong tactics. According to the community-based organizing approaches, successful organizing campaigns

involve thought, planning, and reflection (Salem, Hooberman, & Ramirez, 2005). Thus, how to develop organizing strategies and methods of evaluating campaigns are skills that can be learned.

Community organizing models, while varying in focus, build on the idea that empowerment is internal and that victimized and oppressed people need a new awareness of themselves as people, in a community context, who can both individually and collectively set and achieve goals. This conscious realization transcends personal to political, and draws heavily on the "It takes a village" concept as sources of sustenance. For example, the Chicago Coalition for the Homeless has successfully developed a base community organizing model to build community—and community power to develop programs and inform policy—among shelter residents (Salem, Hooberman, & Ramirez, 2005). Coalition organizers visit shelters, holding "house meetings" with residents to talk about their goals, hopes, needs, and concerns.

Therefore, following a traumatic event, mental health practitioners can use the community-based organizing tradition as a template for bringing together a wide spectrum of stakeholders, conducting assessments, and developing and implementing strategies related to community mental health. From a community-based organizing approach, effective organizers ground their work in theories and use models based on knowledge of issues, groups, and practices from past experiences, people, and events. Ultimately, effective mental health services to communities demonstrate outcomes related to specific strategies, exhibit increased levels of community empowerment, organizing, leveraging of existing resources, and new systems for information dissemination.

## A Mental Health Service Delivery Model for Empowering Host Communities

Disasters may negatively impact a whole community and ultimately an entire society, forcing the community to question the fundamental view of the world as a meaningful and safe place. Many people, though, from the direct effects of the disaster, may also experience trauma. Additionally, the aftermaths of disasters for societies and communities can be long lasting and disempowering. Preparedness and response to natural disasters involves phases of warning, threat, impact, inventory, rescue, remedy, and recovery (Aldwin,

2005; Allen, 2005; Figley, 1995; Gentry, 2005; Langstaff & Christie, 2000; Zimering, Munroe, & Gulliver, 2003). When these phases are applied to communities, similar patterns, symptoms, and reactions occur in the communities' emotional recovery from disaster.

For that reason, recognizing the necessary emotional adjustment can help communities understand the coping process as normal and be prepared to respond in a way that is healthy for its community members and the victims of the disaster. Therefore, reestablishing equilibrium, channels of communication, and meaningful patterns of interaction after a trauma is as necessary to communities as it is to individuals, and thus may facilitate empowerment and a feeling of safety and meaning.

Thus, to address the stress trauma that host communities may experience during a major disaster, I introduce the following mental health Crisis Intervention for Communities (CIC) model. The model is recommended as a mental health tool for practitioners to use to empower those communities and provide them with skills necessary to return to homeostasis after responding to disasters. In short, the model provides guiding principles for assisting humanitarian host communities with recovery efforts. Although the model touches on all aspects of the trauma phases, it is the recovery phase of traumatic stress that applies to humanitarian host communities.

This CIC model is multidisciplined in that it borrows from various disciplines such as mental health, education, social psychology, sociology, and anthropology. Thus, inherent tenets, assumptions, principles, and strategies from multiple perspectives, including crisis and secondary trauma (Figley, 1995; Marotta, 2000; Pearlman & Saakvitne, 1995; Zimering, Munroe, & Gulliver, 2003); helping (Winton, 1995); mental health and diversity counseling (Sue, Ivey, & Pedersen, 1996); community-based organizing frameworks (Conway & Hachen, 2005; Galea, Ahern, & Resnick, et al.; Kulka, et al.,1990; Levy, Anderson, Issel, Willis, Dancy, Jacobson, et al., 2004; Podair, 2005); and ethics (American Counseling Association, 2005; Disaster Relief, 1994; Fluehr-Lobban, 2003) into one model to create a comprehensive plan for providing mental health services for host communities.

This simple four-part model assimilates components for mental health crisis counseling, effective communication, multicultural considerations, and ethical concerns. It begins with the relocations

of victims to safe communities. It focuses on the relocation of persons from multiple traumatized communities in a natural disaster, while closely examining interactions among victims of disasters and the humanitarian host communities. Taken together, CIC speaks to how different communities, because of culture differences of both the victims and the members of the host community, may be affected differently by the integration into one community.

### Mental Health Crisis Counseling

To begin, community disaster prevention organizations can contribute vastly to minimizing the scope of damage, by conducting their own evacuations when disaster strikes. Therefore, Part One of the model requires mental health assessment procedures for everyone including those communities involved in the disasters, using systemic mental health services—from the victims to the helpers.

From a crisis and trauma perspective, we know what to do when a disaster strikes. According to the National Center for Posttraumatic Stress Disorder, reactions to disaster can be categorized into the Impact Phase, Recoil and Rescue, and Recovery Phase. Therefore, these categorical phases provide a template for focusing on the trauma of communities. For example, in the impact phase, the majority of communities that were directly assaulted reacted appropriately by protecting the lives of their own community members as well as the lives within other communities.

Some of those communities, on the other hand, like people, found themselves disorganized and stunned, unable to protect themselves. Without external intervention, this may continue into the postdisaster period. Several community stressors associated with impact that later affects the community may occur, such as fatalities, feeling of helplessness and vulnerability, and unavoidable terror (Breslau, 1990; McCall & Salama, 1999; Shelby & Tredinnick, 1995).

The Recoil and Rescue Phase is the phase where a community recoils from the impact and the initial rescue efforts begin. From a mental health perspective, the community may be confused, and high anxiety is evident. Similar to individuals, during this phase, group reactions (e.g., denial, flashbacks, anger, despair, hopelessness) may vary and depend on the community's history and experience with the different community stressors elements.

The last phase, Recovery, is the prolonged period of adjustment or return to

equilibrium that the community must go through. It begins as the rescue is finished and communities are faced with the task of returning to normalcy and rebuilding. For the humanitarian host communities, this time is similar to a honeymoon. During this period, the community may be basking in their altruistic and unselfish responses to the disaster victims.

Later, after reality of unexpected financial and social costs and of other burdens sets in, humanitarian host communities may experience more stress. As a consequence, they may need channels to voice and process their discomfort, concern, and dissatisfaction with the unexpected costs of the sacrifices made. Fortunately, much can be done with relatively simple means at the community level to reduce mental health trauma on humanitarian host communities as a result of the impact of natural disasters. Through this model, a compassion fatigue framework allows us to expand our mental health services to the humanitarian individuals, families, and communities involved and volunteering to help.

### Effective Communication:
### Community Organizing

In Part Two of the CIC model, facilitating effective communication is central to those communities where evacuees choose to become permanent residents. It helps the community frame its vision, set agendas, and facilitate integrative dialog and conversations in terms of what will make the community a better place for new and existing community members. At this juncture, the host communities may determine what best fits with the dynamics, demography, preference, and concerns of their communities.

According to the Red Cross, communities often have to respond quickly to emergencies. As a consequence, the model incorporates some of the basic tenets of community-based organizing approaches, where mental health clinicians can equip communities with skills to organize their communities, community leaders, and resources in a manner that effectively addresses their concerns. As part of this process, mental health practitioners may apply organizing strategies to community mental health including identifying and recruiting prospective community leaders and providing them with leadership training that emphasizes the continuities between community members and community leadership, between private and public issues, and between the underlying community's goals. Thereby, host commu-

nity leaders, via encouragement from clinicians, are empowered to take the lead, with input from their community members, and determine what issues would be the focus for their residency activities.

### Multicultural and Diversity Considerations

*The dinosaur in the living room: Race and class of Hurricane Katrina.* Wolf Blitzer's (2005), statement on live television: "You simply get chills every time you see these poor individuals. Many of these people, almost all of them that we see are so poor and they are so Black, and this is going to raise lots of questions for people who are watching this story unfold," opened up the floodgates to dialogues on racisms and brought attention to apparent racist and racially insensitive remarks that people, including President Bush's wife, Laura, were making about the victims of Katrina. Fortunately, the one positive outcome of Blitzer's comments was that they brought much needed attention to the dinosaur in the living room, namely race and class, that the media seemed content to ignore.

It was the poorest, the neediest, and the most helpless stranded, in dire stress, waiting to be rescued, and holed up in the New Orleans Superdome, and the majority of those were Black and poor folks. As a result, questions relating to racism emerged such as, if these were White people stranded in an American city in 2005, would it take the government so long to respond? In spite of the issues relating to racism, there was no major or serious coverage from the media of the issues of race and culture. This was reiterated by Shafer (2005) who wrote in his column that television coverage backed away from talking about race and class. Shafer believed that those in the media were ignoring the fact that almost all of the victims in New Orleans were Black and poor.

*Culture and trauma.* Part Three of the model, therefore, considers the diversity of people, culture, and customs involved in helping in major disasters, and in this manner, is framed in culture, diversity, and multicultural perspectives. It also draws heavily from the tenets of multicultural and diversity counseling, primarily because a diversity framework is responsive to culture and trauma, including diversity factors existing in communities such as race, class, gender, and religion. Ironically, for the counseling profession, the very foundation of the American Counseling Association Code of Ethics (2005) is

multicultural in nature and grounded in diversity. For professional counselors, this means that not to consider the cultural background of a client is unethical and ultimately harmful.

As in the case of Katrina, perhaps less out of malice or racism and more out of being unprepared and political correctness, like the media, mental health clinicians, associations, and experts were remiss in acknowledging that the majority of evacuees were poverty-stricken, Black, and coming from areas high in social ills such as crime, violence, and drugs. Our professional mental health associations avoided speaking to the issue of race and poverty by not posting on their webpage or making readily available culturally sensitive and responsive mental health crisis information, strategies, and techniques or materials that addressed issues of trauma and culture.

Looking further at the case of Katrina from a community mental health prospective, knowing that the majority of Katrina evacuees being relocated to other communities are poor Black people and from traditional New Orleans ethnic communities, are important variables to consider when relocating them to communities that are ethnically, racially and culturally different. New residents in a community are likely to have widespread effects on the host community, thereby changing substantially and permanently the structure of the of host communities.

In terms of socioclass the cliché of "charity begins at home" may be relevant to most host cities and communities with large homeless and destitute populations. That is, one should not give to charity what was paid for in justice. Accordingly, it is important to consider the adverse effects and the ethics involved in bringing, in essence, strangers into the communities and providing them with permanent housing, health care, food and clothing, and other emergency services, while virtuously ignoring the housing and emergency needs of the homeless and poor people who already reside in the host cities and communities. In essence, it seems rather naïve not to consider that the relocations of the evacuees into these communities just might generate negative repercussions and harsh feelings from the communities' homeless people. The ethical question to address, from a comprehensive mental health perspective is, "Do homeless people deserve the same considerations and help as those who were made homeless by the Hurricane Katrina."

To facilitate the transition, the CIC model emphasizes the need to incorporate mediums for local-level conversations between residents and victims of the disaster about their different values, customs, and culture differences of the people. Clinicians are ethically obligated to use culturally sensitive and responsive counseling and strategies.

Further, especially with culturally diverse communities, this process may involve realizing cultural differences and then integrating multiple systems and levels of leadership—personal, family, and community. Thus, the difference in the type of disaster, cultural backgrounds of the victims, and cultural backgrounds of the volunteers can influence the structure of the humanitarian host community and the delivery of services to the evacuees. For the host communities, this includes facilitating local-level dialogue between residents and victims of the disaster about their different values, customs, and culture, especially creating channels that allow the host community to share its rich history and its heritage considering and acknowledging the culture of the evacuees.

The host communities' reactions to the change may vary depending on customs and values and the diversity (ethnic, racial, religious, and cultural make-up) of both the host community's residents and the disasters victims. In the case of Katrina, monitoring the effects of relocating African American New Orleans folk into predominantly White, or to culturally diverse communities and ethnically different neighborhoods and communities, is necessary and critical for everyone's emotional health as well as the successful transition of evacuees into host communities.

### Ethical Concerns

Part Four, the final phase of the CIC model, refers to ethical concerns and obligations. There are both national and international codes of ethics for volunteers helping in a crisis or disaster situation. Likewise, mental health professionals have ethical codes and guidelines to adhere to when providing mental health services. For example, knowing what the professional ethical guidelines are for working with people who have been severely traumatized such as adhering to the International Red Cross and Red Crescent Movement and Nongovernmental Organizations NGOs Code of Conduct (Disaster Relief, 1994). It is equally important to apply ethical codes when working with communities (Fluehr-Lobban, 2003).

The International Red Cross and Red Crescent Movement and Nongovernmental Organisations NGOs involved in Disaster Relief came together to created a Code of Conduct (Disaster Relief, 1994) in order to set standards for disaster response that were later endorsed by eight of the world's largest disaster response agencies. The Code, though unenforceable, is being used by the International Federation to monitor its own standards of relief delivery and to encourage other agencies to set similar standards.

The code adheres to 10 simple principle commitments. First, the Humanitarian imperative comes first, and second, aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. The third commitment is that aid priorities are calculated on the basis of need alone, and fourth aid will not be used to further a particular political or religious standpoint.

The fifth principle states that disaster response agencies shall endeavor not to act as instruments of government foreign policy and therefore, sixth, respecting culture and custom. The sixth commitment encourages the agencies to attempt to build disaster response on local capacities. The seventh principle requires that they find ways to involve program beneficiaries in the management of relief aid.

The eighth principle addresses the goal that relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs, whereas the ninth principle addresses accountability; they hold themselves accountable to both those we seek to assist and those from whom we accept resources. And the last principle speaks to empowerment and the inherent worth of people; the commitment states that in their information, publicity, and advertising activities, they recognize disaster victims as dignified human beings, not hopeless objects.

This part of the model also addresses the ethical duty to be aware of the importance of culture and diversity. Ethically, practitioners should create opportunities for the victims of disasters and the communities to raise each party's awareness of the others' cultural differences and perspectives, thereby fostering a culturally sensitive environment to learn how to listen to each other and create avenues where host community members can voice their concern or commit their support. These created mechanisms help empower communities to frame the issues and decide on strategies, ultimately leading to organizing

cultural transformation by emphasizing individual and community accountability, and by establishing new social norms.

Lastly, in order to facilitate healing after trauma, there should be some training and information sharing on both primary posttraumatic stress and compassion fatigues at the individual and community levels. Psychoeducational and efficacy techniques act like enablers increasing the boundaries for the host community, and thus people's ability to be involved in their shared communities. And like any other effective mental health treatment plan, evaluation, termination, and follow-up services are necessary.

### Implications and Conclusion

Experience is suggesting that the impact of Katrina goes well beyond the development and implementation of mental health improvement for evacuees. The information provided herein consists of suggested guidelines for developing strategies and interventions for host communities coping with the transitions and assimilations of evacuees. As previously noted, mental health services should empower these communities by helping them appreciate the value and understand the benefits of as well as the risks involved in helping people affected by major disasters. From the host community perspective, this awareness should be expanded to be inclusive of the both permanent and new residents' shared values.

It may be too early to articulate learned lessons from Hurricane Katrina, but from a community mental health counseling perspective, like Katrina, as clinicians, we don't want to get caught with our pants down. According to social exchange theory people help each other when there is a positive cost-benefit analysis; when the benefits (tangible or intangible, physical or psychological) outweigh the costs (Winton, 1995). So what happens when the resources are depleted and people stop helping the victims? For sure, we know from history, research, and our experiences that there are going to be residual effects of the relocation of evacuees on communities long after the news coverage has ended and the floodwaters have receded.

Perhaps, the one lesson we as mental health practitioners could learn from this comes from W. E. B. Dubois (1996) who asserted in 1903, over a century ago in his treatise on the souls of Black folk, "The problem of the twentieth century is the problem of the color line—the relation of

the darker to the lighter races . . . in Asia and Africa, in America and the islands of the sea" (p. 10). Sadly, the lesson learned from all indications, based on federal government's response to the Gulf Coast disaster and the media, government officials, and mental health professions' shyness in acknowledging or lack of commentary on the fact that the majority of the evacuees of Katrina were destitute Black individuals—is that the color line, integrated with race and class, is still a problem over a century later.

As we saw with Katrina, logistically, if we wait around for official government support to arrive at the disaster area, we lose too much time. Therefore, for communities under attack, it is imperative that they have on-the-spot resources to make the initial response. It is important to note that crisis and trauma mental health skills may be applied to communities and individuals at all levels and every stage of the disaster.

Thus, by addressing the mental health services of host communities now, assimilation problems are minimized; this makes the transitions smoother and less harrowing for people who have already been severely traumatized. Moreover, it is important for mental health practitioners to empower communities to understand the role they play in effectively addressing trauma with interventions used that are viewed as culturally sensitive, substantive, and credible. Especially empowering for everyone involved in a disaster is having a voice.

## References

Aldwin, C. M. (2005). *Stress, coping and development: An integrative perspective*. Boston: Butterworth Heinemann, Sage.

Allen, J. G. (2005). *Coping with trauma. Hope through understanding* (2nd ed.). Washington, DC: American Psychiatric Press.

American Counseling Association. (1995). *ACA code of ethics and standards of practice*. Alexandria, VA: Author.

Blitzer, W. (2005, September 1). New Orleans' hurricane evacuees. CNN's *The Situation Room*.

Breslau, N. (1990). Stressors: Continuous and discontinuous. *Journal of Applied Social Psychology, 20,* 1666-1673.

Conway, B. P., & Hachen, D. S. (2005). Attachments, grievances, resources, and efficacy: The determinants of tenant association participation among public housing tenants. *Journal of Urban Affairs*, *27,* 25-52.

Disaster Relief. (1994). *Code of conduct for the International Red Cross, the Red Crescent movement and the nongovernmental organizations*. Geneva: International Federation of Red Cross and Red Crescent Societies.

DuBois, W. E. B. (1996). *The souls of Black folk*. New York: Penguin Books.

Figley C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those treating the traumatized*. New York: Brunner/Mazel.

Fluehr-Lobban, C. (2003). *Ethics and the profession of anthropology: Dialogue for ethically conscious practice* (2nd ed.). Altamira Press.

Galea, S., Ahern, J., Resnick, H., et al. (2002), Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine 346*(13), 982-987.

Gentry, J. E. (2005). Compassion fatigue: Our Achilles heel. In J. Weber, D. D. Bass, & R. Yep, *Terrorism, trauma, and tragedies: A counselor's guide to preparing and responding* (2nd ed.). Alexandria, VA: American Counseling Association.

Ghahramanlou, M., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal for Emergency Mental Health, 2*(4), 229-240.

Gulliver, S. B., Knight J., Munroe, J., et al. (2002). Secondary trauma in disaster relief clinicians at ground zero. Presented at the 18th Annual Meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.

Herman J. L. (1992). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., et al. (1990). *Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans Readjustment Study*. New York: Brunner/Mazel.

Langstaff, J. C., & Christie, J. (2000). *Trauma care: A team approach*. Boston: Butterworth Heinemann.

Levy, S. R., Anderson, E. A., Issel, L. M., Willis, M. A., Dancy, B. L., Jacobson, K. M., et al. (2004). Using multi-level, multi-source needs assessment data for planning community interventions. *Health Promotion Practice, 5,* 59-68.

Marotta, S. A. (2000). Best practices for counselors who treat posttraumatic stress disorder. *Journal of Counseling and Development, 78,* 492-495. National Center for Posttraumatic Stress Disorder.

McCall, M., & Salama, P. (1999). Selection, training, and support of relief workers: An occupational health issue. *British Medical Journal, 318*(7176), 113-116.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Vicarious traumatization*. Nevada City, CA: Cavalcade Productions.

Pergram, C. (2005, September 9). *Texas requests funding for providing Katrina relief*. KUHF, Houston Public Radio.

Perlman, S. D. (1999). *The therapist's emotional survival: Dealing with the pain of exploring trauma*. Northvale, NJ: Jason Aronson.

Perry, R. (2005). Gov. Perry establishes Texas disaster relief fund. Office of the Governor: Press Office.

Podair, J. (2005). Neighborhood power. *Journal of Urban History, 31,* 746-752.

Salem, E., Hooberman, J., & Ramirez, D. (2005). MAPP in Chicago: A model for public health systems development and community building. *Journal of Public Health Management and Practice, 11*(5), 393-400.

Shafer, J. (2005). The rebellion of the talking heads: Newscasters, sick of official lies and stonewalling finally start snarling. Retrieved October 11, 2005, from http://slate.msn.com/id/2125581/

Shelby, J. S., & Tredinnick, M. G. (1995). Crisis intervention with survivors of natural disasters: Lessons from Hurricane Andrew. *Journal of Counseling and Development, 73,* 491-497.

Skovholt, T. M., Grier, T. L., & Hanson, M. R. (2001). Career counseling for longevity: elf-care and burnout prevention strategies for counselor resilience. *Journal of Career Development, 27*(3), 167-176.

Soloman Z., Oppenheimer B., & Noy, S. (1986). Subsequent military adjustment of combat stress reaction casualties: A nine year follow-up study. In N. Milgram (ed.) *Stress and coping in time of war: Generalizations from the Israeli experience* (pp. 294-315). New York: Brunner.

Stamm, B. H. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.

Sue, D. W., Ivey, M. B., & Pedersen, P. B. (1996). *A theory of multicultural counseling and therapy*. Pacific Grove, CA: Brooks/Cole.

Wagner, D. (2005, September 24). Katrian evacuees blast FEMA's efforts: Arizona is standing ready to help Rita's victims. *Arizona Republic*. Retrieved October 5, 2005, from ttp://www.azcedntral.com/arizonarepublic/local/articles

Weber, J., Bass, D. D., & Yep, R. (2005). *Terrorism, trauma, and tragedies: A counselor's guide to preparing and responding* (2nd ed.). Alexandria, VA: American Counseling Association.

Winton, C. A. (1995). *Framework for studying families*. Guilford, CT: Dushkin.

Zimering, R., Munroe, J., & Gulliver, S. B. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times, 20*(4). Retrieved October 5, 2005, from www.psychiatrictimes.com/p030443.html