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## Navigating the Maze of Disaster Mental Health: The Journey of the Palo Alto Medical Reserve Corps

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# Navigating the Maze of Disaster Mental Health: The Journey of the Palo Alto Medical Reserve Corps\*

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## Abstract

This paper introduces the Palo Alto Medical Reserve Corps (PAMRC); a program which focuses on disaster mental health education. The reader will be provided with background information on early intervention following a trauma and be introduced to the challenges encountered by the organization during its conception and development and to those faced by mental health professionals as communicated to PAMRC representatives during their response to Houston, TX in the wake of Hurricane Katrina. The conclusion of the article will delineate the philosophy and methodology utilized by the PAMRC and describe the efforts of the PAMRC to set in motion a collaborative approach to disaster-related challenges, regardless of specialty.

**KEYWORDS:** psychology, emergency response, Palo Alto Medical Reserve Corps, volunteer, challenges, Katrina

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## INTRODUCTION

The following document introduces the Palo Alto Medical Reserve Corps (PAMRC); a program which focuses on disaster mental health education. The reader will be provided with background information on early intervention following a trauma and be introduced to the challenges encountered by the organization during its conception and development, and to those faced by mental health professionals as communicated to PAMRC representatives during their response to Houston, TX following Hurricane Katrina. The conclusion of the article will delineate the philosophy and methodology utilized by the PAMRC and describe the efforts of the PAMRC to set in motion a collaborative approach to disaster-related challenges, regardless of specialty.

## FOUNDATION AND MISSION

Following President Bush's 2002 State of the Union Address in the wake of the terrorist attacks of September 11, 2001, The Office of the Surgeon General established The Medical Reserve Corps (MRC) program. The MRC program provides would-be volunteers a means via which to come together and contribute their skills and expertise to their communities and nation in times of need. MRC units serve their communities throughout the year as well as during times of crisis, and supplement existing local emergency response organizations within their region and often throughout the country. As an organization designed to provide services ranging from education to preparation and response, the MRC encompasses units throughout the nation. For more information on the MRC program, please visit (<http://www.medicalreservecorps.gov>).

Professionals at the National Center on the Psychology of Terrorism (NCPT) and the Veterans Affairs Palo Alto Health Care System (VAPAHCS) established the Palo Alto Medical Reserve Corps (PAMRC) in 2003. Currently the PAMRC stands alone as the only MRC in the nation which focuses on disaster mental health education and the psychological consequences of disaster. The founding directors and parent organizations of the PAMRC bring together a unique combination of scientific knowledge and practical clinical experience with regard to the treatment of the psychological consequences of trauma. Early in its existence the PAMRC established a mission; to become a "Best Practices Demonstration Model" for the nationwide MRC initiative. The PAMRC Directors and instructors have come together in collaboration from various institutions to develop a program derived from evidence-based and empirically supported sources.

The PAMRC focuses on training mental health workers to respond to the psychological needs of individuals and communities in the wake of mass casualty natural disasters (earthquakes, wildfires, floods) and traumatic events caused by individual terrorists or terrorist groups. Additionally, the PAMRC provides

trauma-related training for first responders to supplement their pre-existing skills in working with trauma survivors. The PAMRC also provides related didactic instruction for academic professionals and interested community members and organizations. The organization embodies a commitment to public outreach and education, and also functions as a consulting organization for agencies that seek to develop disaster mental health programs using alternatives to Critical Incident Stress Debriefing (discussed in detail in the following section).

#### EARLY INTERVENTION HISTORY AND CURRENT STATUS

Tasked with providing education on early interventions for trauma subsequent to disasters and terrorist acts, the PAMRC necessarily must consider the history and current status of early intervention research in the development of all PAMRC programs. In order to better understand the basis of the PAMRC three stage model and the need for alternatives such as that which the PAMRC provides, it is perhaps useful to first acquaint the reader with the history of early intervention efforts following disasters.

Historically, the most common form of early intervention with trauma survivors has been Psychological Debriefing (PD), specifically a form of PD referred to as Critical Incident Stress Debriefing (CISD; Mitchell, 1983). While many organizations continue to utilize this intervention (Litz & Gray, 2004; Litz, Gray, Bryant, & Adler, 2002; McNally, Bryant, & Elhers, 2003), current research on the efficacy of CISD is conflicting at best and in some cases discouraging. While both CISD providers and recipients report satisfaction with the application of CISD there exists a growing body of evidence that this type of early intervention for trauma does not prevent subsequent psychopathology (Bisson, McFarlane, and Rose, 2000; Gist and Woodall, 2000). So while there are convincing humanitarian reasons to provide mental health interventions in the wake of mass disaster there appears to be little empirical support for the most common interventions currently in place (Litz, Gray, Bryant, and Adler 2002).

#### CISD REVIEWED

As CISD is the most common intervention currently used in the wake of a mass trauma it deserves close scrutiny. CISD is a semi-structured group intervention that includes educational as well as experiential components (Mitchell, 1983). The goals of CISD are; to provide education about stress reactions and coping, to normalize reactions to the traumatic event, to promote emotional processing of the event and to provide information about the availability of further trauma related counseling should the participant wish for it.

The CISD approach stems from the crisis intervention tradition and was developed for use with emergency services personnel such as medical technicians and firefighters (Mitchell, 1983; Patton, 1996). In these settings CISD functions

not as a clinical intervention, but rather an opportunity for individuals to share their common normal response to extreme circumstances. The utility of CISD in emergency services has led to the pervasive and routine application of CISD in risky occupations such as the military, even in the face of insufficient evidence for its efficacy in these settings (Deahl et al., 2000).

Literature on CISD clearly states that direct victims of traumatic events, family members of those seriously injured or killed, and those seriously injured in trying to respond to an incident require more extensive treatment and should not attend a CISD session (Dyregrov, 1999). A final concern with CISD lies in the fact that the concept of a direct victim is operationalized as one who sustained physical injury as a result of the traumatic event. This concept of direct victim seems dated given what we currently understand about the long term psychological consequences of traumatic experiences (Galea, Ahern, et al, 2002; Galea, Vlahov, et al, 2003; Gist, 1999; Gist & Woodall, 2000). The CISD protocol further suggests that direct victims are unsuitable for CISD because some quantifiable physical, cognitive, or emotional characteristic of the victim experience makes the CISD process insufficient or inappropriate (Mitchell, 1983).

The research on CISD to date has revealed inconsistencies in application and outcomes with CISD that merit consideration in the formulation of new empirical based early interventions to be utilized in response to mass disasters. The timing of providing PD, specifically CISD has not been empirically studied though it has been suggested that CISD is most valuable when conducted immediately after a traumatic event (Mitchell and Everly, 1986). Additionally, it has been proposed that a possible limitation of past studies of PD and CISD is that they have been studied as one-time interventions which are insufficient and individuals need more sustained participation in further CISD sessions (Litz, & Gray, 2004). Furthermore, despite these arguments, meta-analytic studies of CISD suggest that CISD simply may not be more effective than doing nothing (Rose, Bisson, et al, 2001; Rose, Brewin, et al, 1999). Several authors have concluded that CISD may be an inappropriate intervention immediately post trauma because it involves premature emotional processing of a trauma and without satisfactory protocols in place for follow-up therapeutic processing and intervention (Bisson et al., 1997; Litz, et al, 2002). A limitation of the current literature on the investigation of CISD as an early intervention is that these studies fail to catalog the extent to which participants perceive CISD as an imposition which could aggravate distress.

#### ALTERNATIVES TO CISD

When considering how to intervene in the wake of a disaster it is important to consider risk for the development of PTSD in the effected population. While lifetime risk of exposure to a traumatic event is estimated to be relatively high,

ranging between 60% and 90% the prevalence of Post Traumatic Stress Disorder (PTSD) is comparatively low, with lifetime prevalence ranging from 8% to 9% (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes and Nelson, 1995). Prospective studies indicate that while most individuals demonstrate PTSD-like symptoms in the immediate wake of a traumatic event that it is individuals who fail to recover by three months post trauma that are most at risk for the development of chronic PTSD (Rothbaum, Foa, Riggs, Murdock and Walsh 1992; Koren, Arnon, and Klein, 1999). The implication of these findings is significant in several arenas; the most noteworthy being that immediately following a traumatic event most people experience distress and the vast majority will recover without substantial psychological intervention (Galea, et al, 2003). Secondly, given that most people exhibit PTSD-like characteristics post traumatic event it is critical to distinguish which persons will go on to develop chronic PTSD when considering early intervention techniques and therefore which persons are in need of more intense intervention immediately post trauma. Furthermore it follows that while anyone who has experienced a traumatic event such as a mass disaster may benefit from immediate assistance, the needs of individuals at this stage in trauma response are not for intense therapy that was developed to treat pathological trauma response. Early Intervention research to date seems to support the concept that information gathering and watchful waiting are at least equivalent to and perhaps better than the current standard of CISD in the early stages of trauma response ((Rose, Bisson, et al, 2001; Rose, Brewin, et al, 1999).

Given the current status of early intervention research and techniques; current literature on early intervention advocates psychological first aid as the first stage of early intervention and the model to be put in place on a mass scale immediately following a traumatic event (Litz, Gray, Bryant, and Adler 2002). Focusing more on the psychological consequences of disaster rather than a specific disorder, the PAMRC incorporates this information into its training programs and in collaboration with other sources, has shaped a 3-stage intervention program that can be used as an alternative to CISD and provides intervention options for varying post-trauma time frames.

#### OVERCOMING CHALLENGES: PUTTING IDEAS INTO PRACTICE

The PAMRC currently provides a variety of educational programs for those interested in education about the psychological response to traumatic events and alternatives to CISD. Initially however; the PAMRC was tasked with creating a resident network of disaster mental health providers that could be deployed in the event of a local disaster or terrorist act. Shortly after the organization's inception, the PAMRC confronted the vast multitude of organizations claiming rights to local disaster mental health response. After receiving input from leading professionals in the disaster mental health field, the PAMRC chose to forgo

participation in the pre-existing territorial battle and instead to redirect its programs toward a more effective outlet that would serve all who chose to seek benefit (education). The PAMRC began working with other organizations, including pre-existing mental health response organizations, in an effort to develop a disaster mental health philosophy that would serve the community and fill a previously vacant niche and thus be of service to mental health professionals.

The recruitment of participants for professional training proved a tenuous process even following the terrorist attacks of September 11. With the occurrence of Hurricane Katrina and the frequency of recent disasters throughout the world, interest in and attendance at trainings has increased dramatically. Though many psychologists and other mental health professionals are interested in the PAMRC training and empirically derived response programs regarding disaster mental health issues and research; many are left questioning why professionals should invest time in learning new interventions that their sponsoring emergency response organizations will not support in practice. Additionally, there are many academicians, researchers, and practitioners throughout the country developing their own recommended interventions. The question then arises as to what makes the PAMRC unique in this regard. The answer is optimistically nothing. Hopefully, like other organizations feverishly working to advance the field of disaster mental health; the PAMRC exists to serve, work collaboratively with other professionals, and keep an open door to new research and information as it emerges from the plethora of ongoing research in the field of disaster mental health.

#### EDUCATING THE PROFESSIONALS

Currently, the PAMRC has developed three related courses for mental health professionals (Housley and Beutler, in press). The basic course is the Psychological First Aid (PFA) training. This course introduces the practitioner to PFA and offers specific tools for approaching and interacting with victims during and immediately following a traumatic event. This module is helpful for professionals and others who anticipate responding in the immediate aftermath of a disaster. The intermediate course offered is "Treating the Consequences of Disaster: A Community Model." This training provides an introduction to the psychological consequences of natural disasters and terrorist attacks and the PAMRC's 3-stage, principle-driven intervention model. This module also contains information to address the need for community outreach, education, and collaboration.

The final more intensive course for mental health care professionals covers the PAMRC's 3-stage of model of early interventions following traumatic events; ranging from immediate post-trauma interventions to 1-month post-

trauma. The interventions involved are “principle-based” rather than “theory-based” and tenets and strategies are empirically derived. The principles underlying the PAMRC model were derived from the efforts of the Society for Clinical Psychology (Division 12 of APA) and the North American Society for Psychotherapy Research (NASPR). These organizations convened a task force of approximately 30 professionals and scholars to review all relevant literature on patient, therapist, treatment, and relationship variables. The task force separated their findings to reflect four major problem areas (depression, anxiety, personality disorders, chemical abuse) and extract from each body of research a summarizing set of “principles” that define empirically-consistent guides for clinicians. Thus, the principles are designed to delineate “empirical validation” into a set of integrative and research-informed principles that identify both the status of current research and express this knowledge in a way that can help the clinician organize and follow a treatment plan (Castonguay & Beutler, 2006).

#### A THREE STAGE MODEL OF INTERVENTION

Through working with leading experts, the PAMRC, led by Larry E. Beutler, Ph.D., developed a staged approach to disaster mental health response (Housley and Beutler, in press). Recognizing that the majority of people exposed to mass casualty incidents will recover on their own, the overall goal was to shape a program that would allow for triage and assessment at each stage in order to optimize the utilization of resources. The result of developing the PAMRC protocol based on the principles of therapeutic change is a 3-stage intervention that is flexible (key needs during disaster). Rather than a “cookbook” approach for post-trauma early intervention, the PAMRC’s 3-stage intervention program incorporates skill sets and tools, providing guidance rather than rules to providers on how to use the program.

While the model of treatment developed by the PAMRC is designed to abide by the principles of effective treatment outlined by the joint Division 12/NASPR Task Force; the specific techniques utilized in the interventions are extracted from “empirically supported” interventions to fit strategic needs and principles. This model was designed to address the needs of victims in a sequential and need-based process and follows a three-stage model of intervention: 1) Acute Care and Psychological First Aid, 2) Intermediate Support – Anxiety Management and Coping, and 3) Ongoing Assistance in Coping and Exposure. The first stage; Acute Care, entails evaluation, psychological first aid, and assessment immediately following and up to 3 days post-disaster or traumatic event. The second stage; Intermediate Support, is designed to be applied from 3 days to 1 month post-disaster or traumatic event. Ongoing Care, or stage 3 is delivered 1 month to 3 months or more post-disaster or traumatic event.



Integrated with these techniques are guidelines for assessment. As previously stated, with or without treatment, a large percentage of victims do not qualify for an Axis I diagnosis by the six-month post-event anniversary (e.g., Galea, Resnick, Ahern, et al, 2002; Galea, Vlahov, Resnick, et al, 2003). These findings have called into question the value of instituting broad-ranging and inclusive treatment programs, especially early in the post-event period, since this would result in “treating” many people who will recover without specific intervention. There is currently no consensus on how to identify individuals who are at risk for the development of psychological disorders following trauma, but it is generally accepted that those who exhibit certain initial responses (i.e. numbing, detachment, anxiety, difficulty sleeping, poor concentration, irritability and feelings of reliving the experience) could be at elevated risk. The PAMRC incorporates these factors into a staged assessment procedure and has adopted an approach consistent with the exploration of these possibilities and the fact that the pressing focus of any intervention must be to identify those who are at long term risk as soon as possible, and to intervene with these individuals in order to reduce the rate of long term effects among vulnerable populations.

#### COMMUNITY EDUCATION

The PAMRC also provides training for emergency responders and the community. There are currently two programs for emergency responders; “Working with Survivors” and “Positive Coping.” The Working with Survivors material provides background information on; the psychological consequences of natural disasters and terrorist attacks, recognizing signs and symptoms, tools for working with trauma survivors, and a brief overview of available treatments. The Positive Coping module addresses; the potential traumatic stress an emergency responder may be subject to and offers instruction in positive coping methods that may benefit the individual additional in coping with post traumatic stress. Additional topics such as substance abuse and depression are included within this training course. Due to the unique needs of first responders, the PAMRC has also shaped department-specific trainings by request.

The PAMRC’s course offerings for the community is focused on defining “What is Trauma?” This course covers the basics of trauma, what it is, how it affects people and ways to cope. The PAMRC also offers a Psychological First Aid course for the community. This course is designed to extend the knowledge of the community responder and add key psychological first aid skills to their pre-existing repertoire of emergency response tools, such as CPR. This course includes specific information regarding how to interact with and assist victims during and immediately after a traumatic event.

Community outreach proved a more difficult endeavor than originally conceptualized in the development of the PAMRC. The offer of free programs,

services and information simply proved insufficient and few organizations or individuals chose to take advantage of the PAMRC's programs. In response to limited community interest; marketing efforts were ramped up to include; website development, brochure creation, e-mail flyer distribution, and old fashioned networking. It has taken the better part of 3 years to shape the program to reach current status, and will likely take additional years to continue this development and allow the PAMRC to reach optimal potential for the organization.

#### DEVELOPING COMMUNITY RESOURCES

In an effort to become a permanent asset to the local community's disaster preparation and response efforts the PAMRC has taken significant steps towards developing working relationships with a wide range of community organizations including; the City of Palo Alto, the Palo Alto Citizen Corps Council, Palo Alto Police Department, Palo Alto Fire Department, Palo Alto Office of Emergency Services, the Pacific Graduate School of Psychology and the Early Intervention Clinic for Trauma. Cooperation between these organizations has proven essential in furthering the PAMRC's service goals. In addition to working with these groups, the PAMRC maintains contact with local hospitals including; Stanford Hospital and Clinics, Lucile Packard Children's Hospital, and the VA Palo Alto Health Care System. Moreover, the network of MRC's throughout the nation provides ever present support, encouragement, ideas and opportunities for education. The ability to be of service and to coordinate with other MRC's has been an indispensable part of the PAMRC's growth. Through various connections established by both the directors and instructors along with outreach to the community, the PAMRC has been able to provide training for professionals and graduate students at various universities and hospitals, first response organizations, psychological conventions, and various community agencies.

#### THE PAMRC PHILOSOPHY

Before reviewing the recent experiences of PAMRC volunteers with regards to disaster mental health response, it may helpful to review the philosophy of the PAMRC. The growing pains associated with development of the PAMRC unit, challenges faced in building community outreach services, and the encounters PAMRC representatives have had with other professionals and organizations like those described above have punctuated the continued need for the PAMRC to create and uphold a philosophy of education and response and to use that philosophy in shaping its program and activities. Though focused primarily on mental health and not the broader concerns of disaster response; the PAMRC's approach is presented here for the reader's consideration with the hope that in sharing one organization's approach, others will be encouraged to respond with their own ideas and techniques. Perhaps then working in collaboration, the many

organizations working in disaster response will create new opportunities for the study and advancement of interventions that prove efficacious in disaster mental health response.

The philosophy adopted by the PAMRC is one that is pragmatic, open, non-territorial, and encourages an inclusive team approach to tasks and activities. The PAMRC does not advocate for or against specific disaster mental health interventions; but rather exemplifies a commitment to providing participants with the latest information available. From this information, the PAMRC then encourages the course participant to come to their own conclusions regarding the strategy and efficacy of treatments.

Organizationally, the PAMRC staff and volunteers are encouraged to take an active interest in one another's responsibilities. As a volunteer organization, the PAMRC is fortunate to have working within it individuals who are passionate about their tasks. This passion is applauded and supported and the interests of staff and volunteers are supported and nurtured. For example, new staff/volunteers are paired with more experienced staff/volunteers and are mentored within the PAMRC program with the purpose to assist them in reaching the goals they have set for themselves. Weekly meetings and regular communication help the organization progress. A team attitude is fostered and the sharing of tasks is encouraged. Respect is a central tenet of the organization, both for internal personnel and individuals and groups external to the organization. The PAMRC places value on its ability to find common ground with other organizations and endeavors in disaster mental health response and also in finding creative ways to develop mutually beneficial relationships with other organizations.

#### A FOCUS OFF PTSD

The PAMRC concurs with current findings in early intervention research that in focusing solely on ASD and PTSD a practitioner could miss the variety of other problems potentially presented by the disaster victim. A broader conception of treatment that is easily adapted to variety of conditions is needed. Therefore, the PAMRC addresses the psychological consequences of disaster rather than focusing on only one specific syndrome or disorder. The 3-stage model taught by the PAMRC essentially serves as a "tool-box" for the potential disaster mental health care responder.

The nature of disaster requires interventions that are flexible and adaptable, and thus the PAMRC has aimed to provide the practitioner with tools which are flexible and can be adapted to whatever situation may be encountered. This "tool-box" is regularly revised to address new information in the field of early intervention and to incorporate potentially useful new mechanisms for intervention. As an organization, the PAMRC strives to keep an open mind and

encourages discussion and dialogue about new and promising intervention techniques. The experiences of responders are valued heavily and the PAMRC shapes its approach to providing intervention training programs based on what field providers have indicated has proven most useful.

Disaster response, regardless of service provided, is not a tidy mission that can be completed using a recipe-like manual. Response requires creativity, flexibility and adaptability. First and foremost response requires a willingness to serve. Volunteers are individuals with unique interests and skills. The PAMRC encourages potential mental health response volunteers to look critically at the types of service they wish to provide and to match their volunteer efforts with those services. Assistance of all kinds is valuable. If a professional is willing to entertain the notion that one of the most important interventions is getting someone a bottle of water and addressing immediate needs which may be lower on Maslow's scale than traditional mental health concepts; head toward the front lines. If a volunteer or professional is more interested in treating the long lasting effects of trauma, perhaps that person can set aside time to do pro-bono work from their office in the months following the disaster. Opportunities to volunteer are endless and as varied as the individuals who choose to volunteer. The PAMRC encourages volunteers to search for volunteer prospects which align with their expertise and motives to volunteer.

#### ROLE OF THE COMMUNITY IN RESPONSE

Disaster mental health care may be provided by professionals, but the PAMRC recognizes the essential role the community plays in its own long-term mental health. The majority of contact a person has while at a shelter is with other survivors, not necessarily mental health professionals or other volunteers. Therefore, educating community members about what traumatic reactions can include, what can be done to cope with such reactions and what can be expected is essential in supporting a community efforts to self help and self heal.

Emergency responders often carry the brunt of the burden during a disaster and have, until recently, served as silent and little known heroes. The PAMRC appreciates that first responders possess unique needs and constraints in dealing with disasters. The PAMRC supports these responders and understands that the culture of each response organization and department is different. Therefore, the PAMRC tailors its services to meet the unique needs of these departments and strives diligently to respectfully offer services in the most efficient and effective means available.

Psychology professionals do not just provide treatment within the PAMRC model, but also serve as advisors. Additionally, decision makers and leaders often benefit from knowledge of key principles in disaster and terrorism

psychology. Therefore, the PAMRC strives to serve both sets of experts and has provided education on such topics by request.

Though the approach outlined is specific to disaster mental health, the fundamental aspects of the approach is applicable across fields. In summary, the PAMRC strives to use its expertise in a manner that facilitates positive growth, encourages participation, welcomes constructive feedback, considers unique needs, shapes an organization that can grow and change with the continual flow of new information, and that is guided by the needs of those it serves.

#### LEARNING FROM KATRINA

Despite the cogent reasons that exist as motivation for cooperation in disaster response, as observed by volunteers and professionals, it is often strikingly territorial and unorganized. Disaster mental health response appears to operate along the same lines. PAMRC team members were recently sent to Houston, TX following the relocation of Hurricane Katrina and Rita evacuees to work with both adult and child survivors. The PAMRC's response mission was to provide locally based practitioners with "emergency" training in disaster mental health issues and interventions to assist them in developing a cohesive plan for response in their own communities. During this well-received effort valuable lessons were learned about the real-life challenges facing response professionals. The providers encountered by the PAMRC representatives were eager to share their experiences and to engage in dialogue and training in the hope that it might improve future response to such disasters.

The majority of responding professionals who chose to share their experiences with the PAMRC representatives acknowledged the hurdles faced by response organizations and professionals in the wake of Katrina. Respectfully aware that easy solutions are not available, these responders still appeared hopeful that disaster mental health, and other aspects of disaster response, would be more cohesive in the future. Their impressions, though not an exhaustive list of concerns and hurdles, are herein summarized to provide the reader with an overview of some issues which faced field response personnel in the mental health care field. The PAMRC does not necessarily share these views; but in an effort to uphold the philosophy of encouraging discussion, herein presents these issues for consideration and to spark discussion and research.

Anecdotal reports indicated that large response organizations have failed to offer alternative mental health interventions and remain married to an approach to treatment (CISD) that to date is not supported by strong empirical evidence. Many professionals who have been trained in trauma response were frustrated by the fact that large responding organizations often turn them away. To complicate matters, would-be volunteers reported having tried repeatedly to be of service, and despite being told they would be contacted soon, were never again contacted.

Also, evacuees reportedly had little interest in “going to talk with someone,” and few specifically sought mental health assistance. A large portion of mental health volunteers’ energies appeared to be focused on pharmacological and substance dependence problems. Additional reports have suggested that evacuees were more open to “wandering” professionals (professionals who walked around the shelters and made direct contact with evacuees) employing an approach similar to the fundamentals of Psychological First Aid such as that included in the PAMRC’s first stage intervention. Moreover, as has already been delineated, it appears that contained efforts run by smaller organizations seemed to have left responders with more favorable impressions regarding the degree of services provided to evacuees. Additionally, frustrations with the media’s portrayal of the plight of evacuees; considered in accurate and sensationalized, was common and was shared by non- mental health volunteers as well.

Volunteers from the local community as well as other locations repeatedly commented on how the community itself seemed to have stepped forward to assist the evacuees. Residents opened their homes to evacuees and volunteers. Indeed the volunteer representatives of the PAMRC were housed with local residents and often found information from churches and other local organizations more reliable and forthcoming than from larger national agencies and relief efforts. The general atmosphere of the community, as reported by PAMRC representatives and other volunteers, was one of warm welcomes, can-do attitudes, and genuine concern for the well-being of others. In stark contrast to the frustration with FEMA and other organizations, it appeared that the community itself had received a glowing endorsement for its actions in the wake of Katrina.

#### DISASTER RESPONSE IN THE REAL WORLD

Initially, PAMRC volunteers responding to Katrina had hoped to work with and through an agency onsite in the shelters. Despite numerous efforts to contact such organizations and professions of need for the services of the PARMC from individuals with those organizations, return calls were never received. Not to be diverted from the mission of the PAMRC in response to Hurricane Katrina, two volunteers chose to take a risk and head to Houston armed only with a handful of local contacts, laptops, and a sense of purpose. The mission in responding to Hurricane Katrina was envisioned initially to be two fold; to provide training to local mental health providers on stages two and three of the PAMRC model and to themselves work on-site with victims and provide Psychological First Aid.

PAMRC representatives in Houston spent a great deal of initial time and energy e-mailing, talking on the phone, and driving throughout Houston to meet with people in an effort to meet the goals of the mission. As a result of those efforts, they were quickly networked with the Psychology Department at the University of Houston. PAMRC envoys presented an overview of what the

PAMRC could offer the community at the Psychology Department faculty meeting at the University of Houston. In meeting with local mental health professionals some of whom had been working onsite at the George Brown Center and Astrodome they fielded challenging questions about the nature of disaster mental health response, heard about the experiences of other professionals, and learned quickly that the realities of disaster mental health response are complex, often unorganized, normally consist of out-dated treatments (i.e. CISD), and can be entirely demoralizing for the would-be volunteer.

Given that the mission of the PAMRC is as much to assist the providers as to assist victims, PAMRC ambassadors were pleased to provide training on the three stage model developed by the PAMRC for responding to the psychological consequences of disaster. PAMRC representatives also spent a good portion of their time meeting with local health scientists to discuss research proposals and ideas as well as facilitating collaboration between professionals, universities, research endeavors and specialties.

#### A FOCUS ON COMMUNITY NOT SOLELY INDIVIDUALS

In contrast to other professionals who had come to Houston, PAMRC representatives were present not to treat victims for a finite duration but to provide training to local mental health professionals to enable them to meet the long term needs that would be created in their community as a result of Hurricane Katrina. A lasting effect was indeed provided as one PAMRC representative continues to work with schools and displaced children in Houston and the PAMRC has received various invitations to return to the area to conduct training in order to assure a more organized mental health response to any such future incident in that community.

The authors agree that psychologists and the field of psychology are in a unique position to help improve disaster response beyond the provision of disaster mental health services. In an article currently in press titled; *The Dirty Dozen: Twelve Failures of the Hurricane Katrina Response and How Psychology Can Help*, the authors specify key domains in which effort will improve any community's ability to respond to disaster and outline the role of psychologists in effecting change in community preparation and response systems and policies (Gheytanchi, Joseph, Gierlach, Satoko, Housley, Franco, and Beutler, in press). The domains of needed improvement identified by the authors include; communication, command and control, poverty and its effects on community preparedness, response coordination, need for clear and enforced training standards, a focus on broad hazard response as opposed to only counter terrorism response capacity, and personal and community preparedness (Gheytanchi et. al., in press).

The authors of this paper agree with the domains set forth in that article and make the following recommendations with regard to improving future ability of mental health service providers to respond quickly and efficaciously to disaster situations:

- Development of National Standards for Mental Health Disaster Response
- Clear communication of policies on mental health response to all volunteer agencies and organizations, including churches and lay counselors who participate in any relief efforts
- Centralized command and control for all aspects of the relief effort including mental health responders
- Written information for volunteers and agencies involved in response on the “dos” and “don’ts” of talking to survivors about their experience as outlined in the PFA training

In conclusion, the PAMRC model provides a viable and evidence-derived alternative to previous early interventions such as CISD. Staff, project leaders and volunteers with the PAMRC merge a robust combination of clinical and research experience in trauma response. The mission of the PAMRC continues to evolve as new opportunities arise for the organization to be of service to communities which seek to best prepare to meet the challenges of disaster preparedness. Within the complex and territorial environment of disaster response the PAMRC will continue the organization’s commitment to advocating collaborative, empirically derived best practices approaches. While the volunteers following Katrina gained valuable experience and insight into current challenges in the methodology of disaster response, this is useless unless that information is disseminated and utilized to shape current and future research and policy efforts to improve disaster response in the future.



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