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After the Storm: Recognition, Recovery, and Reconstruction

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On August 29, 2005, when Hurricane Katrina made landfall near the Louisiana–Mississippi border, it exposed a large number of people to extraordinary loss and suffering. The enormous swath of physical devastation wreaked across the marshes of Louisiana's Plaquemines Parish to the urban communities of New Orleans and the coastal landscape of Mississippi and Alabama caused a notable change to the demographics of the Gulf Region, making it the most expensive natural disaster in U.S. history. This article describes a disaster responder's experiences of working with displaced survivors of Hurricane Katrina, providing crisis and mental health support in the acute phase of the disaster. This is followed by a discussion of the importance of a multicultural approach to helping survivors of a natural disaster; several guidelines to improve multicultural competence are proposed. In particular, the importance of attending to survivors' racial, socioeconomic, language, and religious differences is discussed.

Keywords: disasters, multicultural competence, first responders, crisis, Hurricane Katrina

In the last week of August 2005, a storm with winds in excess of 150 miles per hour caused 20-foot-high waves to pound the coastlines of Alabama, Florida, Louisiana, and Mississippi. Hurricane Katrina was predicted to hit the Gulf Coast. Severe storm surges caused the breaching of levees in New Orleans, followed by massive flooding as swollen Lake Pontchartrain emptied its waters into the city. Residents who had not evacuated their homes before the hurricane made landfall found their lives in peril. Many communities in New Orleans experienced severe losses in life and destruction to property. The demographics of the city would change notably.

On Labor Day, about a week after Hurricane Katrina struck, I received a call from a volunteer organization in Washington, DC, deploying me to a disaster mental health team in Baton Rouge. A few days earlier, I had indicated my availability as a volunteer on a volunteer site. The caller described the deployment as one of "extreme hardship." I made a decision to become involved in the recovery efforts without much hesitation. I knew that my training as a trauma psychologist, my work as a disaster mental health volunteer, and my past experience as the coordinator of a crisis response team were much needed in the hurricane-devastated region. In reality, I could not shake off media images of the anguished faces of survivors whose lives were forever changed by the havoc wreaked along the Gulf Coast. They reminded me of my clients at an inner city health center in the United States and township clinics I visit during my summers in South Africa.

The next day I arrived in Louisiana, and later that day I picked up my volunteer badge at the Cajun Dome in Lafayette, a small town outside Baton Rouge. In the 1st week after the storm, I was the only person of color on the disaster mental health team, a team designated to meet the needs of 2,500 men, women, and children. Ninety-five percent of the people at this large shelter, where I worked for more than 18 hr a day, were Black and indigent. In this article, I initially describe my experience of working with survivors of Hurricane Katrina, providing crisis and mental health support in the acute phase of the disaster. This description is followed by a discussion of the importance of adopting a multicultural approach to helping survivors of a natural disaster; several guidelines to improve multicultural competency are proposed. In particular, the importance of attending to racial, socioeconomic, language, and religious differences is discussed.

Stories of Survivorship

From the outset, many of us on the disaster mental health team found it challenging to use Maslow's (1962) hierarchy of needs in providing survivors of Hurricane Katrina with the bare necessities to promote their recovery, primarily because basic needs, such as food and water, were in short supply. Although evacuees were given three meals a day, if they did not feel like joining the long lines that usually formed hours before a meal was served or if they were not available at the designated meal times, they had to seek their own sustenance.

Editor's Note. This article was submitted in response to an open call for submissions about psychologists responding to Hurricane Katrina. The collection of 16 articles presents psychologists' professional and personal responses to the extraordinary impact of this disaster. These psychologists describe a variety of roles, actions, involvement, psychological preparation, and reactions involved in the disaster and the months following. These lessons from Katrina can help the psychology profession better prepare to serve the public and its colleagues.—MCR

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All survivors slept in the large open area in the middle of the dome, where football games were usually played. This also served as their primary living quarters and as a storage area for their personal belongings. Each individual was provided with a camp-style cot, which was adequate for a day or two but which took its toll physically when used for more than a week. Privacy was a luxury that was largely unavailable to all survivors who had to share the communal space. Thus, nearly all the residents were sleep deprived, hungry, and agitated most of the time. It was certainly not the optimum climate in which to address psychological concerns.

On a regular basis, anxious individuals inquired about financial reparations to help them take the first steps toward healing and recovery. Many of the evacuees did not know the whereabouts of family members; downed telephone lines made the task of locating them almost impossible. A cell phone company had established a pro bono booth, and distraught individuals who were searching for family and friends waited in line for many hours to use the phones. Many individuals had lost their cell phones and other important personal possessions that stored the telephone numbers of significant others in the storm. They struggled to recall these numbers from memory; as crisis responders well know, remembering even mundane information in a crisis is not easy.

Several Latino families occupied almost half of an upper floor, and many of them attempted to ask me questions. I found myself often shaking my head helplessly to indicate that I did not speak Spanish. I have not regretted not speaking Spanish as much as I did in those 2 awful weeks, when I sometimes felt as powerless as the people I had come to help. On one occasion, a volunteer engaged in the task of making up beds identified a young Latino man as suicidal and in need of mental health support. The young man's wife and children had drowned in the deluge. I was designated to provide him with assistance. In narrating his story, he haltingly described how the local sheriff found the bodies of his loved ones, tied to their beds so that they could die together and not float away in the torrid waters. The distraught young man cherished the water-blemished note written by his wife as she made the final plans for her family's demise.

His sense of loss and grief was tangible; his quest was to identify their bodies so that they could be appropriately buried. The fact that it would take several weeks to complete this important ritual was causing him immeasurable anguish in the form of sleepless nights and decreased appetite. Talking to an unfamiliar woman about his loss was stressful. His helplessness was accented by the fact that he had to communicate in English rather than Spanish, the language in which his memories were encoded. Realizing this, I quickly strategized on how to connect him with other Spanish-speaking survivors, who swiftly formed a warm bond of friendship around him. Days later, observing him animatedly talking within a new circle of friends brought a rare smile to my lips.

The significant role of kinship bonds was evident among many African American survivors, especially those who had lost family members in the storm. It was common to find a neighbor watching over children whose parents were on a treacherous journey back to New Orleans to search for family members, assess the damage to a family home, or salvage personal possessions. Social service organizations and other authorities classified children not in the care of biological parents as abandoned. The media did not hesitate to sensationally broadcast to an anxious viewing audience statistics on the increasing number of abandoned children. Frequently, I found myself advocating on behalf of African American parents by reminding authorities that the children were temporarily in a safe environment, with caring and familiar adults. A request for a broader and more diverse cultural definition of *family* usually led to a little patience on the part of bureaucracy. I was nevertheless always relieved when a mother returned a few days later to resume the care of her children and a potential crisis was averted. By the time I left New Orleans, all the children with whom I had worked were reunited with their primary and biological caregivers.

Religious and spiritual beliefs played a significant role in the lives of many survivors of Hurricane Katrina. It quickly became apparent that many individuals viewed their pain and suffering through a religious lens. To provide culturally appropriate and effective support, responders had to have an awareness of survivors' strong religious values. Stories of being "saved by Jesus" and the belief that the "Lord has a lesson for us" were common; many survivors felt that their religious beliefs had helped them endure the storm. Even children were willing to share religious perspectives on the disaster. Eight-year-old Victoria reminded me, "Jesus and the Devil were fighting on the night that the big winds and tons of water destroyed our house."

Helping in the aftermath of Hurricane Katrina was challenged by the social ills and other problems that survivors faced before the storm. Difficulties in accessing appropriate resources and services after the storm merely exacerbated survivors' existing problems. Substance dependence, psychiatric disorders, domestic violence, and other relational difficulties increased under the intense and stressful conditions of living in a crowded shelter for an extended period of time. Many of these issues kept responders up all night, exploring short-term solutions to domestic disputes, alleviating methadone withdrawal symptoms, and calming down survivors who did not have their psychiatric medications.

Hurricane Katrina has taught us many lessons at the social, political, institutional, and public health levels. For mental health professionals concerned with psychological and behavioral well-being, the most important lesson learned is that strategies for helping should always place culturally specific needs at the core of effective interventions. Helping requires not only good intentions and a willingness to help but also an understanding of the sociocultural needs of a particular community. Culture undeniably influences the meaning individuals attach to a traumatic event; an understanding that suffering and healing exist within a cultural context is indispensable. Another asset is the ability to effectively respond to culturally based cues and discuss cultural issues. The culturally competent responder assesses survivors' functioning on the basis of their psychological, sociocultural, and spiritual beliefs.

Finally, support for the importance of cultural understanding comes from a special report by the Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services, 2003), which maintained that disaster responders should be considerate of a community's history, psychosocial stressors, language, communication styles, traditions, values, artistic expressions, help-seeking behaviors, informal helping supports, and natural healing practices. Minimal guidelines that can inform both local and national efforts in providing culturally appropriate mental health and social services for ethnic minority clients, especially African Americans, in the aftermath of natural disasters are outlined below.

Multicultural Competence

Even when disaster survivors no longer inhabit their original communities, they continue to carry their cultural values and practices. In fact, some values may become more heightened in unfamiliar surroundings. Thus, it is important for helping professionals to understand a client's traumatic experience in the light of cultural and sociohistorical factors (Marsella, Friedman, Gerrity, & Scurfield, 1996). An awareness and acceptance that sociocultural factors integrally affect how individuals respond to experiences, especially traumatic ones, is essential; familiarity with the unique traumatic responses of ethnic minority groups contributes to successful interventions.

In times of crisis and tragedy, cultural and racial affinity becomes strengthened; it can play a critical role in recovery. Relief organizations should therefore make a concerted effort to include responders who are reflective of survivors' ethnic, racial, and social background. For example, studies have indicated that African American clients prefer African American therapists (Ponterotto, Anderson, & Grieger, 1986). Furthermore, many economically disadvantaged groups may have limited experience with mental health services. Aligning clients with responders who are racially and ethnically similar ultimately reduces the stress of cross-cultural interactions. It is likely to be experienced as supportive.

However, establishing racial and ethnic affinity may not always be possible; in its absence, a primary consideration should be the racial attitudes of first responders and the knowledge that open, accepting, and empowering responders help dissolve the initial barriers of racial differences. Training in multicultural competence and experience in working with diverse clients improve this ability. A disaster should not be the arena to test multicultural competence skills for the first time.

Language Barriers

One of the biggest barriers to the provision of culturally competent mental health care is differences in language and communication. In times of stress, it is essential for individuals to express their loss and distress in a familiar language, preferably their native tongue. National disaster response organizations, such as the American Red Cross and the Federal Emergency Management Agency, have a commitment to responding in a timely manner. However, rapid responses often come at a cost to cultural factors, especially in neglecting to pay attention to language proficiency. Recovery efforts implemented after Hurricane Katrina were illustrative of this cultural neglect. For example, in the early stages after the disaster, the language needs of survivors who did not speak English were not supported. As a result, large groups of Spanish-speaking survivors did not receive adequate information about evacuation procedures, the progress of relief efforts, and where they could obtain resources. Most significant, because of language barriers, they were unable to interact with mental health personnel. Individuals with hearing impairments suffered a similar fate. One evening, we sadly observed a deaf teenager depending on her mother to communicate her fear and anxiety and the nightmares she was experiencing from having been forcibly airlifted. None of us on the disaster mental health team had familiarity with sign language; we became helpless witnesses of the mother's distress.

Additionally, it is critical for those in the mental health field to have both an understanding of diverse forms of communication and an ability to communicate in a culturally effective manner. Socioeconomic status, education, and culture influence an individual's pattern of communication. For example, African American communication tends to be context driven (Sue & Sue, 2003). It focuses on the telling of stories rather than depending, as happens in traditional psychotherapy, on verbal communication to describe internal and psychological states. Responders who understand and respect these communication patterns quickly develop rapport with African American survivors. African American culture, especially in the South, favors physical contact to illustrate connection. A grasp of reassurance or a strong handshake should not be underestimated for its healing powers. It was common for survivors to use endearing terms and to prefer a hug to a handshake. In contrast, survivors who perceived helpers as holding negative perceptions about their language and manner of speaking hesitated to ask for help.

Socioeconomic Factors

All disaster survivors must learn how to manage a shattered world, to mourn unraveled relationships, and to cope with having witnessed death and destruction. Such coping decreases confusion and increases resilience by ultimately creating physical, emotional, and spiritual balance. However, financial preoccupation inevitably impedes the recovery of socioeconomically disenfranchised individuals.

African Americans disproportionately bore the brunt of suffering and loss after Hurricane Katrina. The Ninth Ward, 98% African American before the storm, was completely obliterated. The skewed extent to which African Americans were affected by this natural disaster is often attributed to preexisting and ubiquitous social and economic disparities; earlier census reports indicated that 127,000 New Orleans residents did not own cars (Van Heerden & Bryan, 2006). The hurricane magnified these disparities and attracted the attention of a wider audience so that they could no longer be ignored.

Thus, in the aftermath of the hurricane, a question remains about whether the lack of a timely rescue effort was motivated by the underclass status of most of the survivors, their minority status, or both. Unfortunately, a poorly planned local and state response and delayed involvement by the federal government increased the feelings of marginalization many indigent survivors already felt; it contributed to their rapid psychological disintegration and loss of hope.

The tragedy that occurred in the Gulf Coast primarily exposed the socioeconomic stratification prevalent in the United States. However, because most of those affected in New Orleans were Black, issues of racial disparities and unfair treatment by authorities also surfaced; the complex nexus between race and class differences emerged. Nevertheless, socioeconomic factors played a major role in the dispersal of the African American population of New Orleans; poor people seldom have choices. Hurricane Katrina exposed their vulnerability and helplessness; it continues to influence the direction of reconstruction in New Orleans by determining who returns and who rebuilds. For example, ethnic minority groups often rely on low-income and moderate-income rental homes (Fothergill, Maestas, & Darlington, 1999). However, the

rebuilding of these homes has been particularly slow after disasters, causing housing shortages that inevitably affect the stability of ethnic minority communities. This may explain why many African American residents who were evacuated after the storm have not returned to New Orleans; their hesitation to return may stem not from a lack of motivation but from a lack of basic shelter. Survivors continue to be plagued by the limits imposed by a low socioeconomic status, especially in accessing housing. Until these basic needs are met, attention to mental health needs will be severely delayed.

Institutional and Cultural Mistrust

African Americans whose ancestors endured slavery continue to live in a cultural environment that contributes to their mistrust of institutions. For example, African Americans often view the criminal justice system, educational institutions, and other government agencies with suspicion and cynicism. Human service agencies such as the Federal Emergency Management Agency, the American Red Cross, and mental health institutions are not exempt from this suspicion and mistrust. First responders should be prepared to deal with African Americans who may prematurely desist from seeking help because they lack confidence in an institution's ability to offer them adequate assistance (Terrell & Terrell, 1984). Responders, who may be motivated by a desire to help and support survivors, may find this distrust difficult to understand.

However, this distrust is not unique to African American communities but also evident among other ethnic minority groups. For example, two studies noted that Asian American immigrants' distrust of the U.S. government prevented them from seeking disaster services after an earthquake in California and a hurricane in Alabama (U.S. Department of Health and Human Services, 2003).

Collective Worldview

Many ethnic minority groups share a collective worldview that places greater importance on the community and the interrelatedness and interconnectedness of all things, including nature and physical place. The ecosystem that surrounds an individual influences his or her functioning. Survivors of Hurricane Katrina, who were forced to make new homes in distant U.S. towns and cities, have experienced a rupture in their ecological framework; in addition to their physical losses, they have lost all that was familiar. Research has found that survivors of a natural disaster who remain in familiar surroundings are able to maintain family cohesion and preserve psychological community; such survivors are also able to contribute to the recovery and reconstruction of their community (Galante & Foa, 1986; Najarian, Goenjian, Pelcovitz, Mandel, & Najarian, 2001). In contrast, those who relocate to distant areas experience a loss of connection and a weakening of communal ties. Time will shed greater light on the long-term psychological consequences of forced distant relocation on the lives of survivors of Hurricane Katrina.

An ecological consideration of an individual's political, cultural, environmental, and social realities has the additional benefit of helping responders identify his or her support networks (Kaniasty & Norris, 1999). Beaver and Miller (1992) differentiated between formal and informal community support networks, arguing that both are equally important in helping survivors recover. Formal support networks are usually those services provided by governmental and other nongovernmental organizations. A community's history with these institutions determines how this support is viewed. Family, friends, and community members provide informal support networks and can become a primary source of support, ameliorating the negative effects of stress for some survivors. For example, research shows that adults who are 65 and older receive more than 80% of their support after a disaster from informal support networks (Bowie, 2003). Similarly, Tyler (2000) found that older adult survivors of a Midwest flood who possessed secure social support systems experienced fewer depressive symptoms compared with those with minimal support.

When natural disasters occur, everyone in a community is affected, albeit not equally. However, the commonality of the experience gives survivors the opportunity to share experiences with each other; this decreases a survivor's sense of isolation and carries the potential to bring people together. Disasters allow the inherent good in human nature to emerge: racial unity, unexpected acts of kindness, an increase in tolerance, displays of courage, concern for others, and a sense of goodwill. For example, in the aftermath of Hurricane Katrina, many families living in towns surrounding New Orleans did not hesitate to temporarily shelter displaced survivors. Churches provided clothing and meals for the destitute, and residents of neighboring communities volunteered at local evacuation shelters. De Wolfe (2000) described this phase of a disaster as the honeymoon phase, a period of benevolence that, unfortunately, does not last forever.

The World Health Organization (2003) advised disaster response organizations to make every effort to collaborate with local resources, including traditional healers, when responding to affected communities. In this way, psychosocial interventions become locally available and culturally appropriate. Such responses maximize the use of community resources, increase the well-being of community members, and strengthen disaster-affected communities. Community leaders and local healers who receive adequate consultation and support can take the lead in designing community interventions (Reyes & Elhai, 2004). Because they have knowledge of the unique needs of their communities, they can assist in problem solving and designing interventions. If they are direct survivors themselves, they are in a strategic position to involve survivor communities. For example, a few disaster responders supported several survivors, who were school personnel before the storm, in their attempts to make educational plans for children at the shelter where I worked. Perhaps the major benefit of collaborating with community members is that it restores a community's sense of control and leaves people with the feeling that they have contributed to their own healing.

Finally, community responses can sometimes make up for the physical losses individuals suffer in the aftermath of disasters. Despite substantial material losses incurred by local residents after the collapse of the Teton Dam in Wyoming in 1976, several community interventions optimized their recovery and fostered an integrated community (Golec, 1983). Moreover, these interventions maintained social networks, provided individuals with financial compensation, and ensured an adequate supply of resources.

Perceptions of Help and Healing

White, middle class values of individualism, autonomy, and an internal focus have strongly influenced the practice of Western psychotherapy and mental health practices (Atkinson, Morten, & Sue, 1998). In contrast, many ethnic minority groups, especially African Americans, view their problems as primarily residing outside of the self (Sue & Sue, 2003). Thus, responders working with African American clients may have to seek ways of helping that have an external rather than internal focus. In addition, traditional mental health approaches encourage detachment and objectivity and discourage the giving of advice and suggestions by the helping professional. African American clients may perceive the neutrality of the therapeutic helper as emotionally distancing; such a stance may obstruct the development of a genuine helping relationship (Schiele, 2003).

People of African ancestry culturally value authenticity and a full range of emotional and therapeutic expression. Responders who do not hesitate to express grief and outrage in response to a survivor's suffering may be experienced as more genuine. Such displays of emotional vulnerability contribute to the building of a positive human connection. Finally, responders in a natural disaster must be open to reevaluating the relevance and appropriateness of conventional practices and their past training; flexibility in adapting one's therapeutic style to conduct culturally appropriate interventions is a major asset (Carter, 2004; Peregoy, 1999).

Religion and Spirituality

Religion, defined as an organized system of beliefs, practices, and rituals designed to facilitate closeness to God (Koenig, McCullough, & Larson, 2001), is positively embraced by many ethnic minority groups as a way to understand personal suffering and loss (Taylor, Chatters, & Levin, 2004). In particular, a belief in a divine force that intervenes in one's life is consistent with an African cultural worldview (Grills, 2004). Individuals living in the South display a similar religious faith (Taylor, Thornton, & Chatters, 1987); prayer is used as an integral source of coping in the aftermath of personal tragedy or adversity (Taylor et al., 2004). African American survivors are likely to struggle with a spiritual explanation of why a tragedy has befallen them. They may display fluctuations between intense emotions of loss and gratitude for survivorship.

Disaster responders should be adept at recognizing the values, practices, and spiritual orientations that support a community's psychological and spiritual well-being (Peregoy, 2005; Zhang & Snowden, 1999). Encouraging coping behaviors consistent with indigenous beliefs and customs helps ethnic minority clients heal rapidly; the first responder may have to suspend his or her spiritual beliefs to achieve this. On several occasions, survivors asked me to join them in silent prayer. An older woman took solace in stringing together beads, which she later handed out to people who stopped to chat with her; each bead held a special prayer. Disaster responders who listened with sincerity and unconditional acceptance allowed survivors to explore whatever gave them hope and optimism.

Ministers and other clergy are highly regarded in African American communities; they can potentially serve as first responders. In fact, some survivors may prefer to seek psychological comfort from religious ministers rather than mental health professionals (Neighbors, Musick, & Williams, 1998; Taylor et al., 2004). Others may require both the guidance of clergy and professional counseling as a long-term recovery plan.

Media as a Mixed Blessing

In the aftermath of Hurricane Katrina, the media have turned out to be a mixed blessing. On the one hand, instant and unrelenting reporting quickly drew public attention to the plight of the survivors of Hurricane Katrina. In fact, because the media sometimes reported in areas the Federal Emergency Management Agency and the National Guard had not yet entered, media personnel often became part of the heroic recovery process. In the months that followed, sustained media attention on developments in New Orleans by CNN reporter Anderson Cooper was helpful in keeping the larger U.S. community informed of the rebuilding and reconstruction efforts. It is an illustration of how the media can play a constructive role in the aftermath of disasters.

On the other hand, the media have been charged with a lack of discrimination in communicating the details of Hurricane Katrina. Graphic images continuously presented via television and newspaper coverage contributed to the indirect traumatization of the general public. For individuals with their own past history of loss and trauma, images of death and destruction were profoundly arousing.

The media historically have been remiss in fair and balanced reporting on ethnic minority groups. For example, in the days immediately following Hurricane Katrina, the media often criticized the predominantly African American citizens of New Orleans for not leaving soon enough, for not taking enough food and water when they left, and for recklessly looting. Insensitive labeling of survivors and negative journalistic comments triggered feelings of ethnocultural oppression, racial stigmatization, and stereotyping for many African Americans. Writer Lisa Delpit (2006) described her outrage that the same clips of a few Black residents in New Orleans taking nonsurvival items were aired repeatedly on television in the 1st week of the storm. She saw this as an illustration of the racialization of crime by the media, which used a few Black individuals engaged in illegal behavior to represent the larger group (Delpit, 2006).

Secondary Traumatization

Direct survivors are not the only ones who need support following a natural disaster (Boscarino, Figley, & Adams, 2004; Pearlman, 2005; Stamm, 1999). Responding to the endless needs of a large number of severely traumatized individuals can also take its toll on disaster responders, who sometimes become blind to the negative consequences of helping others. Unconditionally caring and supporting others can deplete responders. Observing social injustices and the pain and suffering of others can trigger a responder's own history of loss and discrimination. Figley (1995) defined this normative occupational hazard of working with traumatized clients as compassion fatigue. Helpers experience this negative reaction because of empathic contact and listening to a client's traumatic experience.

After spending 2 weeks in Louisiana, I found it extremely difficult to transition back to my regular routine. Guilt about leaving survivors who continued to suffer and sadness about their predicament haunted my return. As a person of color, I identified

with many of the people I worked with, and feelings of abandonment dominated my waking hours. Unlike psychotherapists, crisis responders do not get an opportunity to terminate with their clients; thus, closure became an unattainable goal. Ongoing media footage of the disaster did not help me shake off the images I tried to leave behind. Although I was quite familiar with self-care practices that assist mental health professionals in the aftermath of stressful work, my subsequent vicarious traumatization came as a huge surprise. This awareness was a first step in my recovery. Eventually, with the support of family, friends, and colleagues, the heaviness and helplessness slowly dissipated.

Conclusion

Hurricane Katrina was the deadliest and most expensive natural disaster in U.S. history; her destruction is incalculable in terms of loss of life, destruction to property, and economic hardship. The U.S. Department of Transportation (2006) reported that more than 1.2 million people in Louisiana were evacuated before Hurricane Katrina's landfall, and more than 100,000 people were evacuated from New Orleans in the week following the storm. In addition, the Louisiana Department of Health and Hospitals (2006) confirmed more than 1,600 deaths and over 1,000 missing. Never in U.S. history has a natural disaster devastated so many lives. Hurricane Katrina alone accounted for over $80 billion in damages—the highest loss ever recorded from a single storm (U.S. Department of Transportation, 2006).

Moreover, the massive displacement, homelessness, and overall trauma experienced by survivors of Hurricane Katrina will require mental health monitoring for years to come. Providing mental health support during times of disaster can be a stimulating and enriching experience. However, hearing unremitting stories of survivorship can have a deleterious effect on the helping community. First responders must be aware that long hours and intense interactions over a protracted period can be emotionally and physically exhausting.

Despite the sociopolitical disenfranchisement that ethnic minorities experience in the United States, they have been able to maintain a strong psychocultural community with spiritual connections. African Americans, in particular, share a unique collective memory of oppression that requires support and understanding on the part of helpers. Hastily arranged rescue plans may sometimes be inattentive to the multicultural needs of survivors. Responders who sought to offer culturally competent care in the aftermath of Hurricane Katrina had to have an awareness and understanding of language and socioeconomic class differences, the role of institutional mistrust, the collective worldview of survivors, their perception of help and healing, and the importance of religion and spirituality in their lives. This cultural expertise and knowledge allows responders to provide psychological services to the African American survivors of the Gulf Coast tragedy so that the meaning of their loss can be reframed in the context of survival and the resiliency of the human spirit.

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