

Hurricane Katrina: Disasters Teach Us and We Must Learn

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Hurricane Katrina was one of the largest natural disasters our nation has experienced. Katrina covered an area the size of the United Kingdom and displaced hundreds of thousands of people. In this volume, sensitive, dedicated clinicians and educators use their experience to find lessons for our academic community as well as for our entire nation. As educators for medicine and psychiatry, the lessons are important in sustaining a critical component of our health care system—the ability to educate and train physicians and those who give care to the mentally ill, often the most overlooked component of our health care system.

Katrina affected all parts of New Orleans, as well as the entire Gulf Coast. Psychological first aid was an important component of intervention (1–3). The principles of psychological first aid are an evidence-informed approach to providing early intervention after disaster. Psychological first aid has five principles:

1. Establishing safety (physical and psychological)
2. Calming (decreasing arousal, establishing sleep patterns)
3. Connectedness (interpersonal emotional support and instrumental access to knowledge and resources)
4. Efficacy (believing one can respond/act and having skills to act)
5. Hopefulness/optimism

Each of these principles has a strong empirical base which supports its helpfulness in many stressful situations

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in most contexts. There will never be a randomized trial of these principles after disaster, although program evaluations can incorporate these elements into assessments. Debriefing has had a great deal of popularity with first responders; however, for multiple reasons, the literature does not support its use (4, 5).

Communications, housing, contact with loved ones, and the importance of work, where much of one's identity is focused and sustained, are highlighted by Kahn et al. (6). One helps not only students and patients by reestablishing the university and clinical work setting, but also those who depend on jobs, employment, pay, and contact with colleagues as part of their lives. We often overlook the degree to which work is a sustaining and organizing part of life. For children, their work—that is, school—organizes their time, focuses tasks, and provides contact with peers to share emotional events. The same is true for adults and work.

Balancing work and home can be a substantial stressor that is not often examined. Those with more difficulty balancing work and home demands were at greater risk of both posttraumatic stress disorder and depression after the five hurricanes in Florida after 2004 (7). Thus, for us and for those on whom we report, the challenges of wanting to rebuild home and ensuring the safety and comfort of loved ones are compelling pulls from work, as well as reasons to work.

Early intervention after disaster is both a social and health necessity. The need for mental health intervention is substantial and increases as time passes postdisaster. Early intervention requires cultural awareness and both individual and population-level interventions: from public education to screening and health surveillance, and from leadership to psychotherapy, medication, and management of chronic medical conditions (8, 9). Psychological first aid must be combined with needs assessment and an understanding of the epidemiology of disease, risk behaviors, and distress (10).

Those who were evacuated represented another level of needed care and an important setting for university-based clinicians and educators to intervene (11, 12). Evacuation centers highlighted the breadth and depth of this disaster. Posttraumatic stress disorder was not the primary concern. Rather, traditional, severe mental illness and the loss of care for this part of our population was the first concern (13, 14). From drug abuse, schizophrenia, and bipolar disease, those who had evacuated needed their medications and usual avenues of support and care reestablished. In this setting, undetected or untreated medical disease can be the primary presenting cause of psychiatric illness. For example, hypertension can present as a psychiatric care issue in an evacuation center when medicines have been lost.

The academic department is also a workplace, with all of the opportunities and challenges of workplaces (6, 15). Its products are education, research, and clinical care. As a workplace, the academic department requires preparation and planning for disaster. A close integration of human resources, security, employee assistance, and occupational health for the medical school are critical to its function in a disaster (16). Some of the most stressful aspects of disaster recovery can be the downsizing of an organization and the loss of friends and colleagues resulting from economic impact (1, 15). As economic impacts increase over time, resulting health risk behaviors can also increase. Smoking, substance use, motor vehicle accidents, family conflict, and violence, as well as community crime, are long-term costs of large disasters that also affect our universities and their communities. Interventions for these chronic and often forgotten disaster risks are part of our task as educators of our communities, as consultants to primary care and caregivers for the mentally ill in university, hospital, and city communities.

Medical student education, although often the handmaid to residency education, is the core of the School of Medicine's responsibilities (17). As we address our tasks as educators to bring our knowledge to our lesson plans and curriculum for medical students, residents, and graduate physicians, where does disaster psychiatry fit in? Some have begun this task. Does every emergency room rotation include disaster response? Does psychological first aid appear in our training and what we teach? Is public health a viable part of our curriculum? What do we teach about evacuee care? These questions are the outgrowth of the thoughtful and detailed descriptions the authors in this volume challenge us with. Perhaps it is time to address them.

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