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Mental Health Interventions by Telephone with Katrina Survivors

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Much has been written about the delivery of face-to-face mental health crisis intervention services to both disaster survivors and first responders to those disasters.¹⁻¹⁵ In fact, an intense national debate as to the most effective ways to intervene immediately following a traumatic or disaster-related event remains unresolved.¹ In question is the efficacy of a long-standing psychological debriefing procedure, Critical Incident Stress Debriefing. This approach, developed by Mitchell and Everly,^{2-4,5} has yielded somewhat disappointing results according to McNally, Bryant, and Ehlers, who indicate that, “Although the majority of debriefed survivors describe the experience as helpful, there is no convincing evidence that debriefing reduces the incidence of post-traumatic stress disorder (PTSD) and some controlled studies suggest that its use may impede natural recovery from trauma” (p. 45).¹ As an alternative, crisis intervention specialists currently recommend a relatively new approach, Psychological First Aid.^{1,6-8} The principles of this approach, which focuses on meeting each individual’s crisis-related psycho-bio-social needs in a practical manner, through developing an action plan for recovery, among other things, are outlined in significant detail at the National Center for PTSD and the National Child Traumatic Stress Network website.⁹ The effectiveness of this approach requires continued empirical analysis.^{1,6}

Although telephone hot-lines have been considered integral to crisis-oriented mental health services^{6,10,11} since the mid-1950s,¹¹ only one research study⁶ has investigated their use as part of early intervention disaster-oriented mental health services.⁶ Interestingly, the national debate noted earlier has focused primarily on face-to-face contact rather than contact via telephone. Notably, the delivery of mental health interventions by telephone was widely used by the American Red Cross in the aftermath of Hurricane Katrina.

Description of Telephone Services Model

Several years ago, the American Red Cross established a National Call Center in Falls Church, Virginia whose on-going purpose is to act as a 24-hour a day, 7 days a week

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information clearinghouse for callers needing emergency assistance and services as a result of disaster-related losses. The role of the call agent answering incoming calls is to connect the caller with local resources and services near the caller's home area. A unique characteristic of the call center approach is the provision of psychological assistance on an as-needed basis to those callers experiencing mental, emotional, and/or behavioral distress. When a call agent identifies a caller in need of such assistance, a licensed mental health professional is asked to plug in to the agent's phone system to assist with the call. The assistance rendered by the mental health professional is based on the caller's needs and thus, follows an individualized plan as suggested by the Psychological First Aid model.^{1,6-8}

The National Call Center became a major hub for Gulf Coast callers after Katrina. What was unique about Katrina calls was that all callers were using cell phones, since landlines were not functional. Call responders worked eight-hour shifts (7 am–3 pm; 3 pm–11 pm; or 11 pm–7 am) each day. A high volume of incoming calls daily (approximately 100 to 150) was the norm, occasionally resulting in a distressed caller having to talk to a call agent until a mental health worker was available. More mental health volunteers were needed than were available, especially on the night shift, which only had two or three workers (compared with the three to five workers on the day and evening shifts).

My Experience

As a licensed professional mental health counselor and certified American Red Cross Disaster Mental Health worker, I volunteered to assist with the Katrina relief effort and was deployed to the National Call Center in mid-September 2005 for a 12-day period. I attended a mandatory general orientation session the day after my arrival and began working the phones the following day. I worked the 11 pm–7 am shift each night. I was not given specific instructions concerning how to respond to clients but, instead, was expected to do what licensed mental health professionals do during times of disaster. It was emphasized that I should focus on the caller's current crisis-related distress and refer callers needing more in-depth and/or on-going interventions to local counseling agencies. Although prior to Katrina I had participated in the 2-day American Red Cross Disaster Mental Health (DMH) course, this training program, which incorporated components of Psychological First Aid, involved face-to-face contact only and did not include telephonic crisis intervention support as an early intervention after disasters. As a mental health professional, I was ultimately responsible to decide my own course of action as a telephone responder. As described below, the track I took was mapped out using Psychological First Aid. In retrospect, I would have benefited had the American Red Cross included simulated telephonic role-playing exercises as part of its DMH course.

My individualized approach to callers was to engage in active listening as long as the client needed to talk and then to assist the caller in formulating an action plan designed to structure the next few hours or days. Both of these (active listening and formulating a plan) are widely accepted components of the Psychological First Aid approach.^{1,6-8} I used these techniques in an attempt to help the caller acquire a greater

sense of control over his/her immediate environment. Most calls lasted approximately 30 minutes, though a few lasted an hour or more. Except for two obscene phone calls, I always stayed on the line until the caller indicated a desire to terminate. Occasionally, termination seemed premature, and I asked callers to continue talking. By my assessment, callers were, for the most part, shocked, overwhelmed, somewhat detached from reality, and experiencing some degree of hopelessness due to the deteriorated conditions they were forced to endure. Overall, they were experiencing significant emotional distress and cognitive impairment to the extent that they were unable to think clearly or make timely decisions. Many were calling out of deep frustration at not being able to reach Federal Emergency Management Agency (FEMA) Financial Assistance Centers, hoping that I could connect them. (I could not.) Occasionally, I needed to ask for medical assistance and advice for a caller. At such times, I asked nursing staff working with me to assess a caller's pre-existing medical condition(s) and to provide information concerning how to replace lost medications and obtain emergency medical care. Primarily, callers were experiencing significant, but expected, coping difficulties due to the gravity of the disaster. I stressed to them that their fears, anxieties, and depressive reactions, including sleeping and eating difficulties, were, for most of them, very normal reactions to highly abnormal and unusual circumstances. (Those providing disaster-related mental health services generally stress the importance of a normalizing approach.^{2,6,10-13})

The calls I received were uniformly and without question from the poor, the disadvantaged, and those with pre-existing mental and/or physical disabilities. Many callers had experienced difficulty, for a variety of reasons, leaving their immediate environments. Some callers did not have access to transportation and indicated that they were simply forgotten or ignored during evacuation prior to the storm. Some were too frightened to leave and decided to remain in their homes. Others related that shelters near them had closed, that they had no way to get to a shelter, and/or that they had had a bad experience at a shelter and, as a result, decided to return to their damaged homes. A noticeable number indicated that they were afraid to go to a shelter based on media as well as first-hand reports of violence at places such as the Superdome. Some had moved in with other families and were now living in crowded, very cramped spaces with no personal privacy. By their reports, most callers had no one else to turn to at the time of their call, whether they were displaced or still in their own homes.

Telephone interventions appear to have been helpful as callers indicated experiencing a significant sense of relief just knowing that someone cared enough to listen. During the relatively short time I spent with callers, I observed them move from a place of despair and despondency to one where they again felt hope. After talking through the difficult and trying situations they were facing, most callers began to think more clearly and were able to develop an action plan regarding needed changes in their living conditions. The sense of relief in their voices after having the opportunity to discuss their fears, anxieties, and concerns openly was unmistakable. Toward the middle of my 12-day assignment, I began making follow-up calls to check on those people who had seemed exceptionally distraught when they called. In most cases, those I called back had followed through with the recommended course of action and appeared to be coping more effectively. Callers were very appreciative when re-contacted and stated

how validating it was to them that they had not been forgotten. I usually waited at least 24 hours before making follow-up calls.

I found that the time spent in listening and interacting with callers was very meaningful to them. They indicated feeling more confident and stronger after talking with someone, as if they had found a renewed sense of self. Nearly every caller thanked me for being available, while knowing that I had no magic answers. Callers did not expect immediate resolution of their problems; instead, they were seeking some time and attention from someone who cared at a time when their world had been destroyed. The callers I spoke with were very humble and appreciative. It was a distinct pleasure and privilege to be on the phone with them, and their strength and courage is something I will always remember. I doubt I could have coped as effectively as they had with the horrors they had faced and were continuing to face in Katrina's aftermath. I left the National Call Center deeply enriched by the experience.

Examples of Calls Received

Perhaps the most effective way to illustrate my experiences is to describe three of the calls received, and to summarize the action plan formulated during the call. All names have been changed and some basic identifying information altered to ensure confidentiality and anonymity.

Margaret, 73, called from New Orleans to ask if we could assist her in reaching FEMA so that she could schedule repairs to her damaged house. The call agent asked for a mental health intervention as she sounded confused and somewhat disoriented. Margaret told me that she was on a walker and did not leave her home either before or after Katrina as she was frightened that she might fall. In talking with Margaret, she indicated that there was water in her bedroom that she had to wade through in order to reach her bathroom. As Margaret continued talking, she seemed more tired and sleepy than confused or disoriented. **Action plan:** I talked with Margaret about the importance of going to sleep as soon as possible (it was the middle of the night) and to postpone attempting to reach FEMA until the next day. She agreed to this. The call agent had given her several emergency numbers to call to secure assistance in leaving her home if necessary. This information seemed to give her peace of mind. Margaret's 14-year old grandson was staying with her, and I spoke with him prior to the end of the call. He indicated that he would see that she made the calls the following day. I believe that Margaret needed permission to let go of her worries for the night, and that receiving it from the Red Cross call center along with the housing information we had given her made doing so easier.

Patty, 25, called from Slidell, Louisiana saying that she was alone and living in her car due to the damage to her home that made it uninhabitable. She said that her car was not operational and, as a result, that she could not leave the area. She indicated that she was nearly out of her prescribed antidepressant medication. She also reported that, although she had had suicidal thoughts several years ago, she was not currently suicidal. I concurred based on my assessment during our conversation. (Her thinking was clear, logical, and goal-directed with no evidence of suicidal ideation or emotional instability at the time of the call.) I was concerned that, without her medication, she

might become suicidal. Her current inadequate living conditions also needed immediate attention. **Action plan:** Patty agreed to contact emergency personnel in her area to transport her to a local emergency room for continued evaluation and a refill of her prescription. She indicated that she had an emergency contact number for her local area but had not followed through as she had been preoccupied with the aftermath of Katrina. She also agreed to call the American Red Cross for corporate housing. In my professional opinion, Patty was capable of taking these steps, as she did not appear to be mentally or emotionally impaired to the extent that I needed to make the calls at time of our conversation. Triage decisions¹⁰ such as this were a routine part of my assessment procedures. Patty needed a focused plan for the immediate future, which is what I helped her lay out.

John, 45, called from the area of Biloxi, Mississippi to say that he was disabled and had lost his artificial leg and foot in the storm. He was very frightened and worried that he would not be able to replace them as he had no money. He stated that he would not leave the area until he received replacements. He also needed to talk about numerous pre-existing medical problems that continued to worry him. As we spoke, the call agent located a number that he could call to obtain a set of replacement prostheses. This information created a definite calming effect for him. He stated to me how much it meant to talk with someone who seemed to take his concerns seriously. He was very appreciative of my time. **Action plan:** John was more than eager to make the necessary call to replace his lost prostheses.

Conclusion

As noted, the use of the telephone as an early intervention tool after disasters has apparently not yet surfaced in the debate regarding the merit of various approaches to disaster work. The incorporation of Psychological First Aid components in telephonic work is thought to be an important observation in the discussion, however, and depending on research outcomes, may serve to reinforce the use of Psychological First Aid as a routine part of disaster-related early intervention efforts.^{1,6-8}

There is little or no current literature regarding the empirical effectiveness of disaster-related telephonic interventions, which means that there is a need for systematic outcomes assessment. As mentioned earlier, telephone interventions and Psychological First Aid approaches appear to mesh well. Assessment instruments measuring the impact of Psychological First Aid are still being developed.^{1,6} These instruments, when available, may be of great assistance in determining the efficacy of telephonic interventions. Until such time as this occurs, however, the field may have to continue to rely on both call responder assessment and caller self-report regarding both symptom reduction and perceived satisfaction with service delivery as the basis for determining effectiveness. Callbacks, as described earlier, could be an important resource in this connection.

Notes

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