

Katrina Survivors' Psychiatric Needs Unpredictable: 'Cascade of disasters' magnifies trauma.

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Forget everything you learned about treating survivors of the Sept. 11, 2001, terrorist attacks, and the Oklahoma City bombing. The fallout from Hurricane Katrina will be unique in that the mental health challenges facing survivors will be impossible to predict, according to several disaster psychiatry experts.

“In terms of natural domestic disasters, we've never seen anything quite like Katrina,” said Barry A. Hong, Ph.D., professor and vice chair of psychiatry at Washington University, St. Louis. Up to this point, most domestic disasters, including Sept. 11, were confined to a discrete geographical area such as part of a city or a state—not covering an entire city like New Orleans.

In addition, Katrina's devastating blows came in stages. “In some sense, you almost have a cascade of disasters—the hurricane was one, the flooding was [another], and the relief efforts were [yet another] disaster themselves, as was the forced relocation of people,” he said. “We could separate all those, and in the past they were all disastrous things, but not tied into a cascading sequence of disasters.”

Another factor that makes Katrina different from other disasters is the displacement it has created, said Craig Katz, M.D., cofounder of Disaster Psychiatry Outreach (DPO), a New York-based organization that coordinates disaster aid efforts for the psychiatry community.

“We know that one of the best ways to help people recover emotionally from disaster is being reunited with friends and family and having strong social support,” he said. “Here, people are being sent wherever, some with family and some without. That fragmentation is an enormous setup for whatever initial psychological reactions occur naturally, which could coalesce into a longer-term problem that's more entrenched. That's the aspect that concerns me the most.”

The locations to which displaced residents are sent also can affect their psychiatric well-being, said Anthony Ng, M.D., chair of the American Psychiatric Association's Committee on the Psychiatric Dimensions of Disaster. “If people have family in the area, those folks are able to get resettled a bit,” he said. “But a lot of folks ended up displaced [far] from Louisiana or Mississippi, and they may have acculturation stress.”

People often talk about cultural issues such as [those faced by Hispanic] Americans or Asian Americans, but there are also [cultural] differences among African Americans in northern states as opposed to southern states, and even in northern Louisiana vs. southern Louisiana.”

When faced with such an enormous disaster, psychiatric help at the beginning involves just making sure people are functioning reasonably well, Dr. Katz said. “What a psychiatrist can do is make sure someone’s sleeping, eating, and not lapsing into depression and anxiety. That’s an important contribution we can make, not just for those directly impacted, but also for the responders.”

What about medicating these patients? “Some people would say medications are a no-no, but we found after Sept. 11—and I’ve found in other circumstances—that a little sleep medication or anti-anxiety medication to help people relax and sleep better is a humane thing to do,” Dr. Katz commented.

“The literature hasn’t really caught up with that yet, but in my experience, it’s therapeutic.” Supportive listening and cognitive-behavioral therapy also can be useful, he added. “For example, if someone isn’t sleeping, you might be tempted to give them sleep medicine, but instead of just doing that, say, ‘What are you losing sleep over?’ Give the person a chance to talk if they want to.”

Over the long term, posttraumatic stress disorder (PTSD) is an important condition to watch for, according to Dr. Hong. But he noted that PTSD symptoms will not begin to show up for at least a month. “The problem with trying to measure psychiatric or psychological reactions to these disasters is that in the beginning—in the first hours, days, or weeks—people who have a hard time dealing with [the disaster] and those with just ‘average’ reactions are not going to be terribly different,” he said. “We don’t know people have it until they have at least a month of symptoms.”

Most of the time, those diagnosed with PTSD are people with preexisting psychiatric problems, Dr. Hong continued. “This is like a reinjury [to them].” While most people experiencing trauma get back to normal after about a month, PTSD patients employ avoidance and numbing techniques. “They can’t feel anything; they don’t want to watch TV or hear about it or read about it. It’s like they’re walled-in psychologically.”

On other hand, people with more noticeable reactions, such as having nightmares or becoming easily startled, are actually within the norm, Dr. Hong said. A startle response can be a symptom of PTSD, but it is not unique to the disorder.

Such reactions can be misinterpreted by people trying to help disaster victims. “Sometimes professionals or lay people mistake an extreme emotion for something that’s pathological,” he said.

“Inexperienced relief or disaster workers will be exposed to stuff they’ve never seen before. They may see some really huge wrenching expression of grief, and they will think the person’s losing

it. That's a mistake. [When] people have PTSD, you won't even see it. They look like mannequins.”

DPO and Dr. Ng's APA committee are both working on helping out with Katrina's aftermath. DPO has sent members to the disaster area to see where volunteers may be needed, while the APA is working to make sure that psychiatrists themselves are all right, in addition to figuring out where help might be useful.

“The need is going to be very much long term,” Dr. Ng said. “After the water recedes, and people are starting to get back, when the interest is not there any more, and the influx of people wanting to help isn't there, that's when psychiatric needs will come up.”