AFTER HURRICANE KATRINA STRUCK the Gulf Coast in late summer 2005, the landscape was shattered almost beyond recognition. The winds and floodwaters had tossed objects and structures haphazardly across the countryside: large fishing boats were stranded on hills or snagged in the branches of trees and houses had been blown into the streets. Glass, wood, metal shards, downed power lines, and contaminated mud made walking and driving hazardous. In the hot, sultry air, swarms of love bugs stuck to clothing and flesh.

A few days after Katrina made landfall, what I saw in coastal Mississippi—particularly, Biloxi—as a Red Cross mental health counselor was overwhelming for even the most seasoned of responders. Many houses were completely destroyed or severely damaged. At first glance, neighborhoods appeared to be deserted but often were in fact behind hills of rubble— soggy sofas, moldy carpets, water-stained dolls and stuffed animals, mildewy clothing—deposited on front lawns. There were signs of life indicated by makeshift tents, tarps, shelters, and even open hammocks. The homes left standing had Xs painted on their exterior walls, around which numerals tallied the occupants and the deceased.

Those residents who remained, camping inside or outside of their damaged homes and apartments, were stunned and shocked, isolated from their families, friends, and neighbors. They surveyed the destruction but did not know how to respond. All essential services had been disrupted. The water supply was so badly contaminated it was not only undrinkable but risky for bathing. A power outage meant residents had no fans or air conditioning to counter the oppressive heat. The remaining supermarkets, banks, stores, and ATMs were closed down or inoperable, leaving residents without food

or money. Near the beach, steel girders that had once framed office buildings or large chain stores were all that was left standing.

The hurricane shattered support systems and communications. There was no public transportation, no telephone or cell phone service, no Internet connections or e-mail. Schools, set to open for the fall semester, were either too damaged to open or were being used as shelters. Senior centers, civic organizations, and social services were no longer operating; doctor's and dentist's offices had been destroyed. Driving was curtailed for lack of gas and, for those fortunate enough to have a gasoline source, there were no working traffic lights. Dodging debris and downed power lines while gingerly nosing through intersections made every excursion a jaw-clenching ordeal. Most people had fled to other parts of the state or country while others were in shelters run by the Red Cross and other charities.

For many first responders, the only analogs to the landscape of destruction were scenes from World War II movies, such as *The Pianist*. Veterans of the Iraq and Afghanistan wars were reminded of the aftermath of bombings in Baghdad and Kabul. Volunteers and workers from the Red Cross and myriad other organizations, including FEMA (Federal Emergency Management Agency) and similar government responders, found themselves sleeping in churches, makeshift shelters, and, a lucky few, in rooms at local military bases that had withstood the most destructive aspects of the storm and where generators provided electricity.

In addition to those representing government entities or large formal charities, hundreds of private citizens had driven down to the disaster site to deliver clothing or to cook food in their own campers, some vehicles serving as jury-rigged diners in parking lots. Police officers from other communities and states stationed themselves at major intersections and directed traffic.

Despite an influx of donated goods, distribution was difficult. Piles of clothing accumulated outside of shelters and relief staging areas, with dazed residents picking through them under a fierce and unyielding sun. Eventually, rain transformed much of what lay on the ground into an unusable textile soup.

Schools and churches that had sustained minimal damage were used as shelters, often managed by the Red Cross. Displaced families would camp on the floor, forming microcommunities around their cots, self-segregated by race and ethnicity—whites in one hallway, African Americans in another. Yet a third segregated group was young Latino men who worked during the day at construction jobs and returned to the shelters at night to

eat and sleep. Most spoke only Spanish, while shelter volunteers and other residents spoke only English. Announcements and notices were sporadically translated. Celebrities—such as Gloria Estefan, Jimmy Smits, Daisy Fuentes, and Andy Garcia—would periodically visit shelters to cheer up the residents. Feelings toward the Latino residents ranged from anger and resentment to gratitude. They were resented for having jobs unavailable to others and yet appreciated for saving lives during the storm and for rebuilding broken communities.

Conspicuously absent from the shelters were the Vietnamese people who had settled along the Gulf Coast. Many worked in fishing or in casinos or operated small businesses. Having endured wars in Vietnam, arduous and dangerous crossings to the United States—often in fragile boats—and then prolonged stays in refugee camps, Vietnamese families, friends, and neighbors tried hard to stay together. Many did not speak English, and most storm warnings and subsequent relief notices were not translated into Vietnamese. The porches of Buddhist temples and Catholic churches became de facto shelters, with people setting up camp there. And it was at these places of worship where the Red Cross and other charities distributed food, clothing, and cooking supplies. Marines from Mexico unloaded essential goods there, such as bottled water. Vietnamese American doctors set up makeshift health clinics in the temples.

This is a snapshot of a typical working environment for a Red Cross mental health volunteer after a massive disaster. Although every disaster is unique, they have some common threads: physical damage and destruction, social dislocations, chaos, fear, and numbness. The lattice of social networks, public spaces, civic organizations, and socioeconomic supports is left torn and shattered. The social ecology of the disaster—history, culture and social structures, and the dynamics of privilege, power, and oppression—can be seen in the way people respond, such as the segregation within shelters and decisions by Vietnamese residents to stay in their devastated community, resisting another diaspora. Prejudice survives (as expressed by a white man donating clothing: "as long as it doesn't go to those Vietnamese, 'cause they'll just resell them") but may be held temporarily in abeyance (as an African American woman expressed to me: "There is still a lot of racism along the Gulf Coast, but when times are hard, people will pull together and help each other out").

Social and economic inequities are both heightened and ironed out by disasters. People and communities with more resources are better able to

take preventive measures to rebuild and recover. Those who lack opportunity, assets, and social and economic capital because of racism, severe poverty, and linguistic and cultural marginalization are more vulnerable to the effects of storm surges, exploitation by politicians, and neglect by relief agencies that are staffed by predominantly white middle-class people. And yet suffering can also bring people together, if only momentarily.

Disasters are stories of communal destruction and collective loss, as well as individual and family anguish, but they are also narratives of personal and collective strength and resiliency. One story in the wake of Hurricane Katrina is about a Vietnamese couple taking refuge on a dock along a river. The man, in his fifties, was a fisherman whose boat was damaged by the storm. He was concerned that the listing vessel would be looted and ransacked, so he kept an around-the-clock vigil on a nearby dock. His wife was in her thirties and five months pregnant with twins. Neither of them spoke fluent English. The water surrounding the dock was made septic and toxic by the storm. Behind the dock was a field from which chemicals had leached. The U.S. Coast Guard made daily trips to the dock, bringing water and sometimes food. They were concerned about the couple's health, particularly the pregnant woman's, but the man was adamant that neither of them would leave the dock.

The Red Cross asked me to visit the family and assess the situation. With the help of the Coast Guard (which provided a translator), I was taken to the dock with two Red Cross public relations personnel. The trip by boat up the river was surreal as we passed many beached or damaged boats, some resting on land and others with their noses in the water. The Coast Guard cautioned us to avoid being splashed by any water because of possible contamination.

The dock was about fifteen feet above the water table and we ascended a rusty ladder to meet the couple. They had established a camp with tarps, bedding, cooking utensils, and food supplies from the Coast Guard. The woman, Nguyen, seemed cautiously glad to see us, while the man, Van (both names are pseudonyms), was watchful and appeared to be uncomfortable. As we conversed, Van made it clear that he would not leave the dock because of his concern for his boat. The couple had lived in a Vietnamese neighborhood that was severely damaged by the storm, and their house had been destroyed. After lengthy discussion about the risks to Nguyen's pregnancy, he agreed to let her visit a doctor if the Red Cross promised to bring her back to the dock, no matter what was found.

The next day, the same Red Cross contingent, this time traveling on land and minus the Coast Guard translator, drove across the chemically contaminated field to the rear of the dock. Nguyen was ready to leave, while a wary Van said, "Promise bring back?" After reassuring Van, we drove to a local obstetric clinic that was one of few in operation. Nguyen could only tell us that her regular doctor was Dr. Morgan. The only doctor with that name no longer had an office and there was no phone service. Nguyen understood a little English, but communication was challenging. She appeared to be nervous and, when walking from the Red Cross van to the office, held my hand tightly.

The three Red Cross workers were male, as was the obstetrician. The nurses were female. After examining Nguyen and conducting an ultrasound, the doctor asked to speak with me. "She's not pregnant. The ultrasound shows no sign of any fetus." I explained that Nguyen was supposed to be five months pregnant with twins. "She might have been, but she isn't now," he responded. I asked if he could conduct another test, such as a urine sample, to be sure, and although he complied, the result was the same. He did not want to tell Nguyen the news on his own and asked if I would stay in the room with him. I asked Nguyen if she minded, and she agreed to let me be present.

Nguyen appeared to grasp what the doctor told her and started sobbing. The doctor left us alone in the consulting room, and she again took my hand and squeezed it. A nurse came in and mentioned that Nguyen had described some vaginal bleeding a few days before and suggested that this might have been a miscarriage. I told Nguyen that I was sorry for her loss and asked her what she would like to do. She asked to be taken to her house. We went out to the lobby, rejoined the other two Red Cross workers, and drove to her old neighborhood.

The frame of her house was still standing, but the inside had been scoured out by the storm—windows were missing, and walls had collapsed or disappeared. All the furniture and other belongings were ruined. Nguyen began crying again. She again held my hand and asked if I could take her to a staging area in the community to get emergency food and provisions.

Many people were gathered at the relief area. While Nguyen was collecting supplies—rice, water, fuel for the cooking stove—a Vietnamese woman approached me. She pointed to Nguyen and, out of earshot, said, "She not pregnant, she not pregnant," gesturing with her hand in a circle pointed at her head. "She crazy," the woman said and then walked away. When

Nguyen returned to me, she started to sob. Another Vietnamese woman asked me in English why she was crying. Nguyen said something in Vietnamese. I said in English that she had lost a lot. The woman then spoke sharply to Nguyen in English, saying, "What are you crying for? We all lost everything."

As we drove her back to the dock with her supplies, Nguyen asked me in broken English if I was going to tell her husband what the doctor had said. I reassured her that her medical information was private and that she was in control of who she told and what she said. When we returned to the dock, a grim-faced Van was waiting. Nguyen called to him, "Doctor say everything okay," and she waved to us to leave, which we did.

As a Red Cross mental health volunteer, I had many other assignments. I ended up working in the Vietnamese neighborhood where Nguyen and Van had lived. We (I along with other dedicated Red Cross workers, including a nurse, supply specialist, and one of the men who had accompanied me with Nguyen) tried to get the neighborhood some desperately needed supplies—tarps, tents, cots, rice, and cookers. Vietnamese monks, priests, doctors, and many volunteers were trying to help the community recover, even though their own buildings and houses had been damaged. Many people could not call the Red Cross and FEMA assistance numbers because they did not speak English, and even when a translator was available, the lines were often busy. After a few days, the supervisors of the other Red Cross workers reassigned them to other neighborhoods, insisting that they not spend too much time helping any one group of people.

I was more fortunate and was given support for trying to devise culturally responsive services for this neighborhood. As with much of disaster mental health work, I engaged in psychological first aid (see chapter 6), which included a lot of networking, advocacy, and arranging for the provision of concrete services. The local Buddhist temple and Vietnamese Catholic church appeared to be the central point of indigenous responses to the disaster—coordinating distribution of supplies, providing translators, opening ad hoc medical clinics—and equally as important, serving as places where people could gather to socialize, discuss their losses, talk about rebuilding, and identify those in need of special help. I tried to support their efforts, accessing supplies and services when possible and following their lead about who needed help.

While I was working in the neighborhood, the Coast Guard translator called to ask me what had happened with Nguyen and Van. I was not able

to share any details with him other than to say that I had taken her to the doctor. He was clearly concerned about the couple and unhappy with my circumspection. We were able to talk about how the Red Cross might help the couple get funds so that Van could salvage his fishing boat, and I made some phone calls to start this process.

Toward the end of my two-week stint, when I was preparing to return to my family, job, and community, I drove by the dock with another Red Cross worker who had just arrived for a two-week tour of duty. Nguyen and Van were both there, and the situation had not changed. I tried to explain about the calls that I had made about assistance in repairing the boat. Nguyen was smiling and repeated, "Doctor said everything okay." I introduced them to the new worker, and she agreed to visit them again in a few days.

As I drove away, I realized that I still had no idea what had happened and would probably never know. Had Nguyen been pregnant? If so, what had happened? Was it related to the storm and the conditions on the dock? If she was not ever pregnant, what was the meaning of that? Was it a false pregnancy? Was she concerned that her husband, who was in his fifties and wanted descendants, would leave her if she did not bear him children?

As with much disaster mental health work, I had no idea whether I had been helpful to Nguyen and Van. I did not know how many Red Cross workers followed in my footsteps, working with them or with the community to help it recover from the hurricane. Did they remain in their community? Did they even remain together as a family? Are they still grappling with the psychological, social, and economic effects of the hurricane? What enabled them to continue with their lives? These and many other questions remained unanswered.

However, I was able to return to Biloxi two years later in the role of researcher. As described in chapter 3, my colleague Yoosun Park and I worked with Bao Chau Van, a Vietnamese-speaking social work master's student, to interview Vietnamese people living in the neighborhood where I had responded immediately after Katrina (Park, Miller, & Van, 2010). We were interested in understanding their lives before Hurricane Katrina, their experience of the hurricane, and what had happened to them since. The respondents and key informants we interviewed reported that only about half the families that had been living in the neighborhood had returned. There were still many vacant lots and significant numbers of people were still living in FEMA trailers. Many had lost their homes, businesses, and belongings. The costs of rebuilding were prohibitive, and casinos were

gobbling up land, offering high prices to induce selling. Government support for rebuilding was minimal and inadequate. The fishing industry was severely depressed, but this had less to do with Katrina and more to do with the low price of shrimp and the high cost of fuel. Many had fled the area immediately after the storm and had been scattered throughout the United States. The loss of extended family and community left many of them feeling empty and alone. Many of those who returned were still fearful about the consequences of another storm.

Yet a majority of the hurricane survivors were rebuilding their lives and felt positive about the future. They had worked hard, earned money, and reconnected their family networks. Many were engaged in new jobs, often at casinos, or were starting new businesses, such as restaurants. Some had returned to their neighborhoods, while others were living in outlying areas. What was striking was the importance of the old neighborhoods in their lives. People were attending the Catholic church and Buddhist temple, both of which had been central in the recovery effort, offering material, social, and spiritual resources. Social networks had been reconfigured but also reconstructed. Whether the community will continue to be viable as an ethnic enclave is not clear, with many social, political, and economic forces at play. But in the short term, there was evidence of the intersection of individual, familial, and community resiliency.

So although I never knew what happened to Nguyen, and many other people to whom I offered psychological first aid, I was fortunate to witness how a community responded to a major disaster over time—something that eludes most responders who spend only a few weeks working in the early aftermath of a calamity. I learned that despite the ways disaster disrupts lives, overwhelms families, and fractures and shatters communities, people and their communities manage to find many sources of strength and resiliency to help them recover. Yet most clinicians responding in the early phases after a disaster are organized to focus on providing psychological first aid, crisis intervention, and acute mental health services to individual survivors. The work of reconstructing community is often viewed as separate and distinct, the province of public health workers, government officials, and community workers, most of whom do not have clinical training or skills.

This is an artificial dichotomy. Individual and family healing and recovery from disaster are intricately linked to the reconstruction and resurrection of community. Community resilience and individual resilience are intertwined. Approaching disaster from the standpoint of having a social

ecology calls for a unified model—what is referred to in this book as *psycho-social capacity building*—in which the work of disaster mental health clinicians is informed by a person-in-environment perspective. This approach is described throughout. It is contrasted with the more Western, Eurocentric paradigm of disaster mental health services that has dominated the field in the United States and Europe. This prevailing model, with a strong *trauma* orientation to disaster response, has helped and assisted millions of people throughout the world for many years and there is much value in retaining some of its methods and practices. But it has also imposed an individualistic, culturally biased model on much of the world's populations, particularly those living in the developing world, and it runs the risk of producing iatrogenic effects. These effects can turn those being helped into victims who require professional assistance, and they can focus too much on the micro level (individuals and families) while paying inadequate attention to the mezzo and macro contexts in which people's lives are inextricably embedded.

Through my international work in Sri Lanka after the tsunami; northern Uganda in the wake of a twenty-year civil war; Sichuan Province, China, after the Wenchuan earthquake of 2008; and Haiti following the earthquake of 2010, as well as in responding to many large-scale and local domestic disasters, I have witnessed the tension between these two approaches. Increasingly, in non-Western countries or with non-Western populations, those affected by disaster and the indigenous professionals helping them to recover often resist counseling and psychotherapeutic interventions. I have heard many concerns voiced about how Western-style therapy is inappropriate, and even how it disempowers and pathologizes. Also, there are professionals who believe that trauma is rampant and that more therapy and counseling are indeed what is required. This dynamic is further complicated in that some indigenous professionals were trained in the West or exposed during their professional training to theories of human behavior and counseling that originated in Europe and the United States. Whatever one's position in this discourse, it is generally accepted that developing non-Western nations never have enough clinicians on the ground to provide counseling to even a small fraction of affected people. And bringing in outsiders always raises issues about the lack of cultural responsiveness and linguistic barriers to effective communication. Clearly, something more is needed.

Culture is never monolithic or static; there are differences within cultural groups (constituting an array of microcultures) and there are tensions

between traditional cultural beliefs and practices and the increasingly wired, interdependent world. Therefore, in many instances, helping communities to rebuild is enhanced by drawing on traditional cultural practices—these are wellsprings of wisdom and contain narratives of how people have encountered and survived catastrophic events in the past. Large-scale disasters often disorient people, disconnecting them from their traditional cultural practices. Part of the work of disaster recovery is to reconstruct cultural resiliency with the knowledge that the reconstituted culture will never be what it was before the disaster. The disruptions from the disaster event, the changing landscape of the social ecology, and the cultural influences of those who respond from the outside lead to a new set of circumstances facing individuals and communities, as faced by Nguyen and Van and Little Saigon after Hurricane Katrina. Thus, people must reconnect with the stories, lessons, and traditions of the past while also forging a new vision of the future—one that incorporates the past, acknowledges the losses and disruptions stemming from the disaster, and looks forward to a life that contains some measure of hope and meaning.

The charge of disaster responders is not only to acknowledge the vulnerabilities and wounds of disaster-affected communities and their residents, supporting them with evidence-based practices that may involve professionals, but also to recognize the strengths and sources of resiliency that can be nurtured through a psychosocial capacity-building approach. Responders need to respect the inherent strength and wisdom of local communities while also helping to repair the tattered strands of social networks that overwhelmed local leaders are often unable to restore on their own. In some communities in China after the Wenchuan earthquake of 2008, huge numbers of cadres—local governing units essential to the civic functioning of rural Chinese villages—were lost or had themselves lost children, partners, and parents. Given the scale of this disaster, cadres neither were able to respond effectively on their own nor did they have the knowledge, skills, or resources to help their communities recover. Yet it is unimaginable that earthquake-devastated areas in China could be reconstructed without rebuilding the network of cadres; they are essential local leaders and civil servants.

In this book, I integrate the range of models and approaches to helping people recover to offer a comprehensive model of disaster response grounded in an understanding of the social ecology of disaster. Nguyen and Van's losses as well as their potential sources of strength and well-being cannot be separated from their family and community. There is no one way to help *all*

the diverse communities of the world to respond to disasters, although we are continuously developing a knowledge base of strategies and best practices to at least inform and guide our efforts. I write this book in this spirit, with awe and gratitude for all the people who have demonstrated strength and resiliency in their recovery from disaster and for all the people who have helped them in this process.