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Single-Session Intervention in the Wake of Hurricane Katrina: Strategies for Disaster Mental Health Counseling

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What is needed is for our most basic assumptions in psychological thought to be revised from the bottom up. But this revision cannot be made from our offices…

-Ignacio Martin Baro

Hurricane Katrina

Hurricane Katrina formed in the Bahamas on August 23, 2005, crossing Florida before strengthening in the Gulf of Mexico and making a second landfall in southeast Louisiana on the morning of August 29. It was the costliest hurricane in American history, and among the five deadliest in recorded history. The storm is estimated to have caused over $100 billion in damage. Hardest hit of the southern states was Louisiana, where flooding from the storm surge caused a catastrophic failure of the levee system. Ultimately 80% of the New Orleans area would flood, as well as many neighboring parishes. Boats, barges, and cars were pushed as far as 12 miles inland, ramming buildings and causing more damage to the levee system. High winds felled scores of large trees, destroying homes, cutting power lines, and blocking roadways. Weeks after the storm many people in affected areas were still living without power, water, phones, or basic supplies. Four years after the storm thousands of residents were still living in temporary trailers. Over 1,836 people lost their lives in the hurricane and subsequent floods.

Shortly after the storm, the American Red Cross sent hundreds of Disaster Mental Health (DMH) workers to the southern states to provide emergency counseling services to the survivors (Miller, 2006). Most of the counseling that occurred involved a walk-in (or walk-up) single session meeting. This chapter describes some of the counseling work that was carried out after

the storm, with specific attention to the principles of single session therapy relevant to DMH counseling.

Origins of My Walk-In Single-Session Work

My history with walk-in single session therapy began in 1995 when I moved from the US to Canada to join the therapy staff of the Eastside Family Therapy Center in Calgary as part of my-year long doctoral internship in marriage and family therapy. I chose this site to complete my clinical internship because of the pioneering work being done at the center offering a walk-in single session as one of the primary modes of clinical service delivery. I had read about the unique service at the Eastside Center in a groundbreaking article published that year. As a brief therapist, I was intrigued by this briefest of therapies (Slive, MacLaurin, Oakander, & Amundson, 1995). I was skeptical about how useful a single session could really be, but after watching and participating in the service I quickly realized that something special was happening at the Eastside Center. The therapy being done at the clinic was exciting and appeared to be very effective for some client situations. Later I decided to do my dissertation study on the client experiences with this therapy and found that 82% of the clients were satisfied. The majority of those who came for a session reported that they were helped, and more than half felt the single session was sufficient to address their concerns and that no further therapy was needed (Miller, 1996; Miller, 2008). For many of the clients, this was their first time to see a therapist. During follow-up interviews I did with 43 clients in a later study, many told me that they would never have considered going to more traditional outpatient therapy services (Miller & Slive, 2004). They came to the Eastside Center because they felt the walk-in single session intervention was

hassle-free, convenient, and especially appealing because the ability to come in at the moment of need.

One of the most compelling aspects of this therapy was that it seemed to attract a group of clients who would likely benefit from services but would otherwise have been unlikely to access them. Like most therapists, I had worked with many couples and families in traditional outpatient services who had lived with their problems for years, letting them grow and fester before letting reaching such painful levels that they would overcome their fear of stigma and shame to actually schedule a session. The landmark US Surgeon General's report on mental health issues in the America revealed that at some point during their lives about half of the population of the US will experience a situation where they would likely be helped by accessing mental health services. Further, the report indicated that more than half of the people that would benefit from mental health services would never access them because of barriers to clinical service delivery. The three main barriers to service include stigma, accessibility, and cost (U.S. Department of Health and Human Services, 1999; Murray & Lopez, 1996; Rice & Miller, 1996).

After studying the problem of clinical service delivery, I wondered how much more effective therapy would be if clients would come in for treatment when the problem first emerged. Additionally, much of the therapy I had seen in the US was geared to the middle and upper classes. I felt therapy was viewed by the public as an elitist service that only the well-heeled could afford. I was interested in delivery systems that could overcome those barriers to service. The low-cost, non-stigmatizing emphasis of the walk-in services at the Eastside Family Center presented one ideal solution (Slive et. al, 1995; Bobele, Miller & Slive, 2009; Hoffart & Hoffart, 1994; Miller, 2008; Miller, Banks, Goodwin, Fick, Froerer, & Stroyman, 2006; Miller & Slive, 2004; Miller & Slive, 1997; Miller, 1996; Slive, McElheran, & Lawson, 2002). During my

work at the Eastside center I witnessed many examples of how therapists can make the most of a single session in therapy. The lessons I learned taught me that in many situations it was possible to promote a lasting change in a single session intervention, and that one of the most important factors in the process was addressing clients' problems at the moment of need.

I grew up in Louisiana, and began my counseling career in the bayou state in the late 1980's working with underprivileged youth. In the 1990s I was trained by the American Red Cross in Disaster Mental Health counseling, with a specific focus on the ideas and techniques of what is commonly called "psychological first aid" (see www.redcross.org). So when the call went out from the American Red Cross to serve as a first responder to those impacted by Hurricane Katrina, I enlisted along with hundreds of others from around the country. I completed a typical 2-week tour of duty in and around the New Orleans area providing counseling services to the survivors of the storm and supervision to other DMH workers. Before traveling to the disaster area I participated in a Red Cross conference call that provided a briefing regarding the current information about the disaster area, how to prepare for the trip, and what to expect during my deployment. The Red Cross briefer advised DMH workers to prepare for "extreme physical and mental hardship" during the deployment, given reports coming out of the area. The following describes some of my experiences providing DMH services in the wake of the storm. Almost all the counseling conversations I carried out were via single session meetings/interventions, and I found that much of what I had learned from my experience at the Eastside Family Center was applicable in this new setting.

Theoretical Underpinnings of Single Session Disaster Mental Health and Strategies for Intervention

Therapy Begins at the First Moment of Meeting.

This book details many of the theoretical concepts that are common in the practice of the single session therapy in a variety of settings. Some of the theoretical underpinnings and techniques in single session approaches proved especially useful and relevant for the DMH setting. One of the focal points of a single session treatment philosophy is making the most of the time that you have with clients. In more traditional single session intervention services that have developed over the past several decades this has involved designing the reception, waiting area, initial paperwork procedures, and the like to be as time efficient as possible. This principle is true in a disaster mental health setting as well.

On my second day in Louisiana I traveled to the New Orleans area and witnessed some of the destruction that had occurred as a result of the storm and the floods that followed. Eventually I was stationed in one of the small towns north of New Orleans, across Lake Pontchartrain where many of the storm refugees fled and were being temporarily housed in Red Cross shelters. Our mission was fairly simple: assist in the shelter and feeding operations, disseminate accurate information, and provide counseling to those who walked in or walked up, whenever possible. There were few private office spaces available. Many people (including the workers) were living in tents, sometimes located on the highway medians (often referred to as the “neutral ground” in southern Louisiana). The area was still without electricity or water, and so much of the immediate work that needed to be done involved getting people basic supplies, food, and water.

To accomplish this the Red Cross teamed up with local churches, agencies, and other volunteer organizations to establish kitchen complexes where people could come each day for a hot lunch and dinner. For those who were homebound, DMH workers traveled in Emergency Response Vehicles (or ERVs in the Red Cross lingo) that roughly resembled a cross between an ambulance and a delivery truck. The ERVs delivered thousands of boxed hot meals each day by visiting neighborhoods and common areas throughout the affected region. The Disaster Mental Health (DMH) workers split their time between the kitchen complex, the shelters, and as riding along on the ERVs to help deliver food. The basic strategy for the DMH workers was to assist with basic needs while also positioning themselves in places where people with counseling needs would likely visit. This was an effective strategy. About 1 in 20 people who came seeking food and supplies also showed signs of various trauma responses, and would usually readily engage with the DMH workers. Counseling in this context is remarkably different than traditional clinical services. There is no office, no physical trappings of clinical work, and almost invariably the entire therapy was this single meeting.

Over the last decade the therapists at walk-in single session services have experimented with various “first questions” for the therapists to ask early in the session to help promote a solvable framing for the problem and the greatest efficiency in a 50 minute session (Miller, 2008; Slive, McElheran, & Lawson, 2002). The following questions, common in brief and solution focused approaches, have proven to be useful in that they do not focus solely on the problem, but on what pragmatically will work for the clients. These questions are useful in that they orient the therapist and the client toward a solvable framing of the problem with a clear direction to proceed. These questions can be modified for DMH work.

What is the single most important concern that you have right now?

This was perhaps the most important organizing question for the DMH counselor to ask. The range of needs for those who came seeking help was great. Some people were looking for someone to talk with about a family member or neighbor that was in need of counseling help, but they did not know where to turn. Some were dealing with grief and stress from the sudden upset to their lives that the quick and massive migration from the storm area had brought. Others were looking for someone to talk with about their own grief and trauma response given that they had lost a family member in the storm, or couldn't find members of their family and feared that they had not survived. Some people were dealing with the sudden stop to their lives that had occurred after the storm. Almost all businesses, services, social events and the like, had ceased.

Depending on the client situation, the therapist had to judge what was the most important type of help that was needed, and prioritize needs (i.e. triage). Focus had to be kept on addressing the most immediate and critical needs first, while keeping the other needs in mind. Sometimes this level of help required the therapist to connect the client with physical resources, such as food and shelter services. Others benefitted more from connecting with family members and the information networks that were established to locate displaced people. To be most effective as a DMH worker it is important to maintain accurate information about various services, supports, and agencies that can help clients with their physical needs.

The list of information about these resources changes hourly in a disaster setting, as new resources become available and others run out. My experience with the disaster response setting is that there are multiple agencies converging to provide help, some with overlapping needs or mutual support networks (i.e. one agency has supplies, the other has the capacity to deliver

them). Often there is a seasoned Red Cross worker or other agency worker who has a wealth of experience and is current on the ever-changing information about what resources are available. Knowing this information is critical in providing help, so I quickly learned to connect with these seasoned workers and keep a notebook of resource lists that I would update frequently.

People usually try to resolve a problem themselves. What things have you tried?

This is a typical question in brief therapy, but it takes on new significance in the DMH setting. Many people have dealt with trauma or loss in their lives in the past and have learned a few things about their personal and interpersonal resources. Or, they have already begun the process of putting their lives back together, but simply need encouragement to continue in the efforts they have already begun to implement. This question can help orient the client to existing strengths and resources. The question can sometimes promote a more hopeful attitude for the client about the situation, which is often the first step in the healing process. It also helps to know what clients have tried already to avoid doing more of something that is not working.

What inner strengths would it be useful for us to know about?

Again, this is a typical question in brief and single session therapy that fits well in the DMH setting. The studies of "resilience" in people after they have experienced a trauma tell us that there are several key factors that tend to promote positive healing and change in the wake of a crisis. Strong family relationships that foster the ability to develop shared meanings of difficult events shape the foundation of resilience. Other factors include strengths such as a positive outlook and purpose provided by spiritual convictions. Other resiliency resources include having a sense of hope, a feeling of personal control, creativity, and even the ability to utilize humor

(Walsh, 2006). Exploring these resiliency factors can be a powerful intervention in helping people begin the process of putting their lives back together in the wake of a disaster.

What will be the smallest change to show you that things are heading in the right direction?

A core initial step in many psychotherapy models (i.e. strategic therapy, cognitive behavioral therapy, solution focused therapy, etc.) includes the process of helping the clients identify and prioritize problems and goals. When there are many problems or goals, the prospect of dealing with them can feel overwhelming for the client. By asking this question in a DMH single session, you help the client sort out the chaos of the situation they may be experiencing. Breaking the issue down further by focusing on what is a step that can be taken even in this one meeting can give the client some sense of control of the situation that otherwise feels out of control. The job of the therapist in helping the client manage this issue often involves thinking smaller, rather than bigger. As the popular quote by Confucius goes, “the journey of a thousand miles begins with a single step.” In DMH figuring out what this first step will be can be the most important step of all.

Pragmatics versus a Specific Model of Intervention

Each of the DMH workers had their own approach, model, and style for doing therapy. When possible, the DMH counselors would work in pairs as a therapy team. This promoted safety and collaboration. Although no one model of therapy is employed in the disaster situation, many of the therapists that provided services tended to use some components of solution focused or brief therapy techniques. In what has become tradition in most single session approaches, one

fundamental goal of the service is to provide clients a clearly identifiable outcome at the end of each session not limited to assessment and referral. This outcome is often small and guided by the client's stated goal. To accomplish this in a single session, therapists have found that specific therapy models tend to be less important than attention to pragmatism: actions and beliefs must be judged by their practical results (Amundson, 1996). Results are evaluated based on whether the session was able to meet the client's stated goal, not on whether the problem was solved. In a DMH setting the goal is not to resolve the problem, but to help clients have a safe place to talk about loss (if they choose) and deal with the range of feelings and difficulties that are currently present. It can be tempting for some therapists to go in other directions that might be more typical in outpatient practices. Adjusting to a more pragmatic approach can be challenging for some DMH therapists, but it is essential to be most effective in the limited time available. Adjusting to an attitude of pragmatism can sometimes challenge the more sacred and deeply felt beliefs about what therapy is and how best to provide it. This orientation to pragmatism is radically different from orientations that strive to promote "deep" characterological changes over an extended therapy relationship. To orient clients to this type of service, therapists have found that it is useful to provide a clear message at the beginning of the meeting (Miller & Slive, 2004). A typical orienting message (in addition to confidentiality/duty to warn and consent discussions) might be as follows:

"Before we begin, I would like to take a minute to explain how we work. As you know, this is a volunteer counseling service; you can come as you have whenever we are available and there is no fee or obligation to return. My hope today is that we can work together in the time that we have (usually about 50 minutes) to help sort things out. You are welcome to return for

further counseling any time that we are available, and although you may not be able to meet with me, another DMH worker here will be glad to talk with you."

More is not Better - Better is Better.

Therapists at many walk-in single session centers have adopted a "consumer-driven" view of how to proceed in therapy. An oversimplified way to put it is that the job of the therapist is to find out what the client wants, and give it to them. From this perspective, therapists avoid second-guessing the client's stated goal by looking for underlying pathology or "root problems" only. Instead, the therapist approaches the client as a "consultant," organized by "what the client wants." Often this is difficult for clients to state clearly and requires some processing early in the session to clarify. The therapist's task is to guide this process; paying special attention to avoid providing more help than is requested. For example, a client may not be looking for a solution, but simply for someone to talk with. The therapist accepts this, yet there are some exceptions to this simplified view of problem/goal definition. It is important to note that in certain situations the therapist will be guided first by the ethic of "do not harm." When a child or some other vulnerable client is at risk or there is a risk of self harm or harm to others, the appropriate action is taken (Miller, 2008). The therapist reviews informed consent for treatment and research at the beginning of the session. This includes a description of the limits of confidentiality and the services provided.

One classic example of sometimes providing more help than is necessary can be seen in the use of the Critical Incident Stress Debriefing (CISD) in DMH situations (Kagee, 2002). This intervention for trauma and accident victims was developed in the 1980's and is still widely used. Yet several recent studies have offered evidence that this intervention often does not work,

or does more harm than good with accident victims (Jacobs, Horne-Moyer & Jones, 2004; Mitchelle, Sakraida, & Kameg, 2003). One possible explanation for this surprising finding is that the intervention may provide more help than is needed (or requested).

Timing is Important.

In traditional walk-in single session therapy formats the timing of the clinical delivery is unique in that clients chose the time that they wish to access services. The advantage of this situation is that it captures clients' motivational readiness for change (Prochaska & DiClemente, 1992; Hubble, Duncan, & Miller, 1999). One theory about this arrangement is that changes typically sought in therapy are more likely to occur if the counseling is provided at times when there is sufficient motivation and intensity regarding the problem situation (Berg, 1989; Minuchin & Fishman, 1981; deShazer, 1988). In a DMH setting, the goal is somewhat different from other forms of therapy. The goal is not the typical problem resolution but helping the clients adjust and deal with the range of new needs and emotions that emerge from the trauma. Yet elements of the typical walk-in single session focus on timing are relevant for DMH work. In disaster situations, it is obvious that providing help at the moment of need is critical. For DMH workers, a focus on timing is enhanced by workers positioning themselves in places where those in need will likely come at those moments when they need help. In the response to Hurricane Katrina the DMH counselors often would work with the other aid personnel to help with delivering food, supplies, and medical care. In this way, they could assist the other helpers to provide for essential needs and also be available at times when the need for counseling services was apparent. In this arrangement the DMH worker was also made aware of the complexities of the other aid duties and tasks. This was sometimes helpful when providing counseling to the

other aid workers (i.e. medical services personnel, food supply workers, rescue officers, etc.). Providing counseling services to the other aid personnel is also an essential part of the job.

Relationship with the Service versus an Individual Therapist.

One disadvantage of a walk-in approach is that it is unlikely that a returning client would be able to see the same therapist should they return for another walk-in session in the future (Miller & Slive, 2004). Given this reality, the philosophy of many walk-in services focuses on promoting a relationship between the client and the service, not the specific individual therapists who provided help. In a DMH setting, workers often only serve a 2-week tour of duty in the disaster area before returning home. Ideally, there is some overlap between the tour of incoming DMH workers and outgoing workers to facilitate a smooth transition. When possible the transition can be facilitated by having incoming DMH workers shadow DMH workers that have been working in the area so they can meet some of the members of the community that may come for help. While most clients are only seen once for counseling, some will return for additional support, and this overlap of services can be helpful. Yet after Katrina, the overlap was often limited, so it is important at the end of the session to inform clients that they may not be able to see you again. The DMH worker can reassure clients that another DMH worker will likely be available, that other DMH workers will welcome the chance to talk, and that people can return as often as they want. The goal here is to help clients develop a relationship with the DMH service in general, as well as the natural relationship that occurs with the specific DMH worker.

Case Examples: Intervention and Healing

One of the most gratifying experiences for me was to witness again and again the open generosity of the citizens of the surrounding communities and their selflessness in helping both those fleeing the storm and those who came to help. The natural resilience of these communities and their members was amazing to witness. In this environment DMH intervention often involved helping catalyze these resiliencies as people worked to get their lives back on track. I offer several examples of the type of work to clarify the implementation of single session strategies in DMH settings. These examples are drawn from actual experiences, but have been modified to conceal the identities of the clients and the workers involved. In some situations the example is a collection of several different cases merged together to make clear the concepts that are discussed.

Case Example #1: Making a New Home.

A senior married couple from the lower 9th ward of New Orleans moved to a shelter north of the New Orleans area shortly before the storm made landfall. They were referred to the DMH worker by the shelter manager, who had been working with the couple since their arrival to help them find a new place to live. The couple had been living at the shelter for over 3 weeks by the time they met with the DMH worker. Their home had been completely destroyed by the storm and the subsequent flood. They only had the two pieces of luggage they had managed to bring with them. Most of the other early refugees at the shelter (those that arrived just after the storm) had by then been connected with family or other supports in other parts of the country and had

moved out. However, this couple neither seemed ready to leave the shelter, or felt very happy about staying.

The shelter environments in Louisiana varied greatly. This particular shelter was located in a church that had power and bathroom facilities (outhouse), but no running water. This meant that there were no showers, and no laundry facilities. All the refugees slept on cots and lived in a large open room that afforded little privacy. The DMH worker met with the couple and learned that their main concern was leaving the New Orleans area because they were both born in the area, and had never traveled very far from their home. They expressed their concern and stress regarding the prospect of staying in their current living situation at the shelter, but also did not appear able to make the decision to move anywhere else. In discussing the situation with them they indicated that part of their feelings of "stuckness" came from the difficulty in grasping the idea that their home was now gone. They kept listening to the news and hoping that things would change and perhaps they would be able to move directly back home. Unfortunately, each new report made it clear that this was not going to be possible in the near future. Almost all of their family and friends were located in the now flooded New Orleans area. Consequently, they struggled to find other family outside the storm affected area that would be able to provide housing for them.

One family member that had been located and was willing to accommodate them, was in a northern part of the US. Interestingly the one concern they had about moving was the coming winter season. It was now September, and the move meant that they would soon experience their first snowy winter. They had little experience with snow, and the idea of a snowy winter was anxiety provoking for them both. So many changes had happened for this family so quickly, they struggled to accept it all. The snowy environment symbolized this ultimate change that had

occurred for them. The DMH worker asked questions about this adjustment and what it meant to them in an effort to help them openly discuss each of their individual concerns and their ideas about the best path to take. This discussion included making a list of their concerns and encouraging them to talk about what more information they needed to make a good decision about their next steps. The more they talked about it openly with the worker and each other the less anxious they became about the idea. Before, when the two of them tried to talk about it with each other, their anxiety would quickly rise and they found that they had gridlock in the discussion. In the end, they stated that they felt the DMH worker helped them by giving them a place to talk and express concerns without becoming too anxious. As each concern or issue came up, they discussed it openly and brainstormed about possible solutions.

Eventually they made the decision to make the move, but left open the option to return to New Orleans. They negotiated an agreement with each other that either one could call for this return to their home in the future, and that this would be accepted by the other partner without question. In the meantime they would do their best to make the move go smoothly. The more they discussed the move and prioritized their concerns and needs, the less anxiety they experienced. Towards the end of the discussion, the couple shared their spiritual convictions and how at times they felt that they had to turn over control to a higher power. The couple discussed other faith-based stories about migration and found comfort in thinking about this connection.

This case highlights several examples of how strategies from walk-in single session therapy can be helpful in the DMH setting. First, the therapist accepted the client concern at face value and worked to help them prioritize their goals. The intervention focused on only providing the help that was requested, and was oriented to use the clients' own natural strengths and resiliencies (spiritual convictions; couple support system). The one small step that they felt

would help them begin the process of moving forward was the agreement to move back to New Orleans if they chose. This seemed to have the effect of freeing them to see more options in the situation and lowering their anxiety about making the next move.

Case Example #2: Give and Take.

One DMH worker was stationed at a food distribution center at the center of a small town that had both been hit by the storm and had accepted a large number of refugees from the New Orleans area. Many of the little towns surrounding New Orleans saw their populations effectively double after the storm. At the same time, their own citizens struggled with blocked roadways, loss of power, lack of water, and scarcity of basic services. The loss of power meant that there was no air conditioning; the heat inside homes could exceed 100 degrees in the daytime. The food distribution centers became one of the main community hubs that many people would visit several times a day. DMH workers in this role would help serve the food, while also being available for those who may request counseling support.

The DMH worker observed that one senior man came each mealtime and collected two meals to take away. Most people ate the meals in the large makeshift cafeteria that was provided, because it was powered by generators and was one of the few places that had air conditioning in the town.

One day the man approached the DMH worker and asked if they could talk about a concern he had about his wife. He explained that the extra meal was for her, and that she would come with him each day to collect it. However, she would not get out of the car that he always parked a distance away because she did not want to be seen. The husband told the DMH worker that he was worried that she was becoming progressively more depressed. When the DMH

worker asked what he felt was the main cause of her depression, the husband reported that his wife had always seen herself as a leader and “giver” in the community. He said this had provided her a special sense of pride that was now missing. He offered that she was becoming more and more ashamed and reclusive, as she was required to take food and other support from aid organizations. The husband reported that she more frequently stayed inside their home, which was without power and was badly damaged from fallen trees blown down by the high winds that came through the area. The husband believed that if his wife would “just get out more she would feel better, but instead she hardly ever went out now.” The husband thought that if the DMH worker would come out to his car and “talk some sense into her” that she might not feel so ashamed.

The DMH worker met the woman at her car, and she openly discussed her sadness about what had happened with the storm and how helpless she felt she had become. She wanted to help all the other people that had evacuated, but said she worried that she was not even able to help herself. They discussed her background and the ways that she had been able to help her community in the past. She said that she had herself worked to provide food for the needy of her town. With some pride she said that she was an organizer and that she also enjoyed cooking. As she recounted her history providing food to those in need, her energy picked up and she smiled a bit as she told the DMH worker about her own past aid work. The DMH worker asked if she would feel better about things if she was able to do something to help the community.

After some discussion with the kitchen manager the DMH worker approached the wife and asked if she could help serve food in the kitchen complex. He explained that he had spoken with the kitchen manager and that they were short handed and could use some help, especially from someone who knew the people in the area and had experience in food service work. The

wife smiled widely and said she would be happy to help and was ready to start anytime. Soon both the husband and wife began serving food in the kitchen complex. Her depressive symptoms vanished, and she became a central person in the food distribution center, greeting those who came by name with a big smile.

This case example highlights several elements of single session strategies in a DMH setting. Again, in this situation the worker accepted the client's concerns and goals at face value and provided only the help that was needed. Key to helping these clients was the ability to utilize an existing strength or resource. Fortunately, the client resource also proved to be a resource for the community.

Caring for the Helpers, Self Care and the Unique DMH Setting

The massive influx of people from New Orleans to the surrounding towns created a small secondary crisis that required special consideration and sensitivity. Housing was in short supply and most aid workers slept in makeshift shelters that provided little or no privacy and often lacked showers and other basic comforts. Some aid workers, not wanting to take up space that could be used by others, brought tents and camped where they could find space. In this context an important part of the DMH workers' job was to provide counseling for the other helpers. This involved making sure aid workers attended to their own needs, took breaks from their work, slept at regular intervals, called home to connect with family, and dealt with their own vicarious traumatization associated with the aid work.

In my experience with walk-in single session therapy I have observed that one of the main limitations of the work is not so much the intricacies of the delivery system or issues of clinical technique. The most common obstacle I observed was the mindset of the therapists doing

the work. As most therapists are trained in traditional clinical service delivery practices (outpatient, weekly, ongoing, regular meetings) for those deciding to begin a single session practice there is some adjustment that must be made. At times this adjustment involves overcoming the therapist's preconceptions about the nature of clinical service delivery and change. They often must broaden their perspective to the possibility that in some situations many people can be substantially helped in one meeting. The attitude and paradigm of the therapist is often as important to the outcome of therapy as the dynamics of the actual clinic situation. One of the foundational tenants of the ancient Greeks was to "know thyself" as a starting place in the pursuit of knowing others. Therefore, therapists benefit from some self-evaluation regarding their sense of how well they will work in this environment. Questions that a therapist may consider before beginning this type of work include; *How hopeful am I that meaningful change can be generated from a single-session meeting? How does working from a single session perspective challenge my own beliefs about the nature of people and change? In what ways might my own beliefs hamper my efforts to help people in this type of work?*

In addition to the need for many therapists to challenge their traditional mindset when doing single session work, I would like to share some thoughts for those who are considering applying walk-in single session principles to the challenging, demanding, and (at times) heartbreaking work of disaster mental health counseling. This work is not for everyone, and it is important to consider your own level of comfort for working in this environment before you begin. During my deployment I met with many DMH workers who had been on several previous deployments and had accumulated some tips for those considering the job (Miller, 2006). These included:

- Before your deployment, make sure you will be able to endure the *hardships of the assignment*. If you know that you would have difficulty with limited accommodations, it is better to pass on the assignment and look to provide help in other ways. Assess your own personal resources and your ability to respond to the needs of the deployment.
- When on deployment make sure to maintain some kind of schedule of sleeping and eating. The work can be arduous, but I observed that the dilemma was not getting workers to do the work, but getting them to stop when they were exhausted. There is always something that needs to be done in a disaster area. Without some schedule workers can find that they forget to sleep and eat. As the DMH worker part of your job is to assess if the other workers are overworked or doing enough to take care of themselves. One usual first question that I would ask other workers was to inquire when they last ate or slept. Often they were overdue for one or both.
- Find out the *chain of command* early in your assignment and follow it throughout your deployment. A national disaster area is naturally a place of chaos and confusion. Failing to follow the chain of command will only contribute to the chaos and make things worse. One of the main complaints from workers in a disaster area is the bureaucracy required to get some things done, but avoid the temptation to work outside the system.
- When on deployment, prepare to "*hurry up and wait*" for many of your daily tasks. You will need to be flexible with the organization and your fellow workers. As the DMH worker you are often the one who works to calm the other workers down when they are frustrated regarding the delays and uncertainty that comes along with the job.

- While on deployment make sure to *call home* and connect with friends and family. It will be important for you to maintain your own resources, but it is also important for them to know how you are doing and that you are safe.
- Remember the importance of "*out-processing*" at the end of your deployment. The out-processing is your chance to tell your story about your experiences on the deployment and will provide you with important closure. This process is analogous to the post-session discussion that occurs with the supervisor or team after a single-session meeting in situations where a team or supervision support is included. For some, it is difficult to disconnect from the work when it is time to go home. The DMH worker is the one who usually does the "out processing" session with the rest of the workers when they conclude their tour. This may seem like a minor part of the DMH work, but I learned that it is a very important process. Many workers have experienced traumatic and difficult events and when they return home they may have limited opportunity to discuss what they have seen with others that can relate.

Concluding Thoughts for Walk-In Single Session work in a DMH Setting

Walk-in, single session therapies have developed rapidly over the past two decades. As is true of any clinical modality, it is not a solution for all situations. Yet, as the famous quote by Marshal McLuhan (1964) tells us, sometimes "the medium is the message." In some situations a single session walk-in service communicates to the public that not all problems that therapists treat require invasive, costly, long-term treatments. The medium communicates that for some situations, the natural resiliencies and capacities of people are the most important part of healing, and that the therapist serves as a catalyst for change (versus the origin of change). The therapist is in the role of consultant for change, not the provider of change. Continued research is needed

to determine when this “medium” of therapy is most useful, and when it may get in the way of change. For now it is clear that walk-in single session has great promise in the future development of a coordinated, multi-level response to disaster mental health treatments.

My work with the American Red Cross in Louisiana was the most challenging, yet rewarding work of my career. As my term of deployment ended, I found I was exhausted and ready to go home, yet also reluctant to disengage from the people of Louisiana. As fate would have it, I was traveling out the day hurricane Rita was making landfall. I observed many people panic in the airport, desperately trying to gain passage to sold-out flights. Part of me wanted to keep working and continue helping, but in the end I knew that I would need to heed the advice I had given to others…to know my limits and to let go when it was time to go home.

In this chapter I have endeavored to show how the lessons learned from traditional walk-in single session therapy can be used in a variety of other settings, such as DMH services. This work is one step towards meeting the challenge made by Ignatio Martin-Baro, the father of the liberation psychology movement. His admonishment to our field was to revise our work from the bottom up (from our basic premises) and explore how to help people not only from our offices, but also from the environment in which people live, and struggle to live. This revision must continually look to serve those who may need us the most, not just those who come knocking at our doors. Walk-in single session therapy and the principles that are foundational to this approach provide one useful strategy in this direction.

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