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Stigma of Help-Seeking Behavior Following the Deepwater Horizon Oil Spill

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Abstract. *In 2010 the Deepwater Horizon oil spill in the Gulf of Mexico caused multiple complications for the environment and people living in the rural regions of coastal Alabama. This study seeks to better understand the role of stigma related to help-seeking behavior of those living in the rural communities. Semi-structured focus groups were conducted one year after the oil spill with 21 mental health professionals and staff focused primarily in Gulf Shores and Bayou La Batre, Alabama. Participants described their interactions with clients needing a wide range of services after the disaster. Constant comparative analyses of the qualitative data yielded core themes around self-stigma, public stigma, cultural implications for mental health needs, and impact in the schools. Awareness of community resources, inclusion of key figures in the community, addressing the needs of children, acknowledging cultural differences, and a more thorough understanding of stigma related to seeking assistance as it relates to disasters are key to future planning.*

Keywords: disaster mental health, disaster response, Gulf oil spill, rural social work, stigma

The Deepwater Horizon oil spill captivated the nation and the world during the spring and summer months of 2010. News stations provided round-the-clock coverage of the spill and attempts to cap the well to prevent further devastation. Eleven people lost their lives, and the effects on the communities are still evolving. This disaster is unique to study for several reasons including its duration, the clear blame associated with the disaster, and its impact on two coastal communities: Gulf Shores and Bayou La Batre, Alabama. These very different communities suffered similar fates in the wake of the spill. Gulf Shores, a tourist community, was hard hit in the summer of 2010 as was the rural fishing community of Bayou La Batre. The Gulf oil spill ultimately resulted in the loss of the 2010 economic season with little reassurance of success during future seasons. Unlike disasters such as earthquakes or hurricanes which may last seconds or minutes, the Gulf oil spill lasted for months. Additionally, most people directly affected by natural disasters do not typically assign blame or point the finger at anyone; however, blame was quickly established and directed toward British Petroleum (BP).

The majority of the recovery efforts thus far have centered around the physical environment such as wildlife, the fishing industry, and the appearance of the beaches in the Gulf. What has been largely ignored is the impact of the oil spill on the mental health of people living in the Gulf, particularly those in the rural coastal communities of Gulf Shores and Bayou La Batre, Alabama. This lack of attention devoted to mental health needs is perhaps surprising given the well-documented past research that investigated the impact of previous disasters such as hurricanes in this very region (Aten, Topping, Denney, & Bayne, 2010; Kessler et al., 2008; Pfefferbaum et al., 2008; Roberts, Mitchell, Witman, & Taffaro, 2010; Whaley, 2009). The

purpose of this study was to explore and document the efforts and experiences of rural social work practitioners deployed to provide mental health services after the Gulf oil spill in Gulf Shores and Bayou La Batre, Alabama.

Social workers have a long history of responding to crisis and aiding in emergency situations dating back to the Civil War (Zakour, 1997). This history and experience is important as research has indicated that increased population movement to coastal communities, such as the ones impacted by the Gulf oil spill, has resulted in higher vulnerability to natural disasters (Dodds & Nuehring, 1996). Individuals who are members of vulnerable populations and hail from disadvantaged communities are at greater risk for suffering chronic stress, family disruptions, mental and physical health problems, economic trouble, and community disengagement after disaster (Zakour, 1997). Social work professionals are in a prime position to advocate and provide interventions to those who are most vulnerable before and after a crisis ensue. However, providing crisis intervention and disaster recovery services to rural areas can be difficult and must be grounded in an understanding of the nuances of rural social work practice.

In his review of the tenets of rural social work practice, Ginsberg (2005) noted that fundamentally rural social work is not entirely different from services provided in more urban settings. While the basic elements remain similar, there are unique characteristics of rural social work that must be properly addressed to meet the needs of the communities being served.

The close-knit dynamic often present in rural communities necessitates that people work together to achieve common goals. That is, interdependence is often more desirable than independence because goods and services are often more scarce compared to urban areas. Those dwelling in large cities may be implicitly encouraged to be self-sufficient with little need for face-to-face interaction with others. Conversely, those in rural areas may depend more on neighbors, friends, family, and others in their local community. However, there may also be a sense of pride and a stoic nature of individuals in rural communities when dealing with the financial fallout of disasters, as seen in Alston's (2007) research with Australian farmers after a severe drought. The loss of income paired with higher workload, lack of services available, and lack of emotional support left the families and community in crisis. Many of the farmers utilized rural financial counselors after the drought, but it soon became clear that the farmers and their families needed more than just financial counselors. They needed professional social workers who could understand the reality of rural social work and disaster recovery.

Social workers' adherence to the NASW Code of Ethics is especially critical in rural social work (Daley & Hickman, 2011; Ginsberg, 2005). When ethical dilemmas such as dual relationships manifest in urban settings, practitioners may have the option of transferring clients to other social workers. However, in rural settings, these dilemmas may be unavoidable due to a typically smaller pool of staff to choose from. Interestingly, these dual relationships, while potentially problematic, can be a unique source of cohesion and rapport building within smaller communities. For example, a social work practitioner who is active in the local religious community may become well known by local clients thereby potentially increasing trust in the person as a social worker as well.

Because small towns typically have fewer social work service agencies compared to larger metropolitan areas, rural social workers are called upon to be knowledgeable in a variety of areas to meet the needs of clients (Ginsberg, 2005), which can lead to social workers practicing out of their area of expertise and lead to poor practice complaints (Daley & Hickman, 2011). However, specialization is also highly desirable because other client options for service providers may be a considerable distance away which may not be feasible for clients. Moreover, a social worker might be required to be competent in several subject areas and yet a client may depend on the social worker to possess expertise in a specific area because there are no other treatment options in close proximity.

Rural practitioners providing mental health services often face a multitude of challenges that are less problematic for those working in more urban settings. Difficulty recruiting qualified mental health professionals (Jameson & Blank, 2007; Smalley et al., 2010), less access to healthcare (Safran et al., 2009), fragmented services (Smalley et al., 2010), and higher rates of mental illness and substance abuse (Smalley et al., 2010) contribute to struggles faced by practitioners in rural settings. Despite these shortcomings, Ginsberg (2005) argued that several positive aspects exist for social workers employed in rural settings such as greater flexibility and autonomy, greater potential to advance within the agency, and typically less resistance implementing programmatic change.

Although, by definition, rural areas are relatively small in terms of population, the differences between and within particular communities can vary widely according to race, ethnicity, socioeconomic status, political beliefs, etc. It is therefore crucial that rural social workers embrace the person-in-environment perspective inherent in social work practice and are cognizant of the needs of the local populations they serve. For example, Columbus, Ohio has the second largest Somali refugee population in the United States and, not surprisingly, local mental health agencies have worked diligently to ensure that services are provided in a manner consistent with the needs of the Somali population (Alomari, 2010). Training and hiring BSW- and MSW-level Somali case managers and mental health therapists to work with this population are just a few of the programmatic changes instituted by local agencies.

Additionally, the two rural communities explored in this study are quite different in terms of demographics, despite their close proximity. According to the 2010 U.S. Census Bureau, in terms of race, Gulf Shores is primarily White (97.5%) and Bayou La Batre is more diverse (60.3% White, 22.8% Asian). The large Asian population in Bayou La Batre is indicative of the number of families who, for generations, have worked in the fishing industry. For many, English is not their first language. The median family income of Gulf Shores was almost twice that of Bayou La Batre (\$51,862 and \$27,580, respectively). Despite being located in adjacent counties in Alabama, these small rural communities differed greatly in their makeup.

Previous research has also demonstrated the impact of disasters on mental health across the lifespan. Roberts and colleagues (2010) explored the impact of Hurricane Katrina on communities in Louisiana and found that, in a sample of youth, a substantial number had experienced mental health symptoms two years post-disaster compared to before the hurricane.

Additionally, 79% of the youth had experienced new onset symptoms one year after Hurricane Katrina. The dubious one-year anniversary has also been documented with respect to Post-Traumatic Stress Disorder (PTSD) and the effects on disaster mental health workers responding to 9/11 (Daly et al., 2008). Not only are children vulnerable post-disaster, but older adults are as well. Although age alone is not a strong predictor of resilience and recovery after a disaster, there are certain factors that can increase the risk for older adults including those who have previous trauma exposure, those with limited mobility, and those who have cognitive impairment (Brown, Rothman, & Norris, 2007).

Another critical factor in disaster mental health is the availability and quality of mental health services in the affected areas. The *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness* by the National Alliance on Mental Illness scrutinized all 50 states on the quality of mental health care according to an A, B, C, D, and F scoring system with Alabama receiving a "D" (Aron et al., 2009). The report states that in rural areas of Alabama such as the ones under study, community mental health services are almost non-existent, and there is a general lack of mental health professionals. Further compounding availability of mental health services, Alabama has one of the lowest rates of psychiatrists per capita of any state in the country. The unique characteristics of the oil spill disaster paired with Alabama's low grade presented unique challenges for those working with rural residents affected in Bayou La Batre and Gulf Shores, Alabama.

For the purposes of this study, the focus was on those mental health professionals and staff dispatched to the Alabama coast by Project Rebound, a state initiative created by The Alabama Department of Mental Health. Project Rebound consists of mental health professionals and paraprofessional staff that connect affected individuals to services in the larger social service system during the recovery process post-disaster. Project Rebound was first initiated after Hurricane Ivan in 2004 and was utilized again in 2005 after Hurricane Katrina. Since that time, services have been delivered in the aftermath of disasters across the state of Alabama. In the summer of 2010, Project Rebound deployed staff to the Alabama coastal communities as the oil spill continued to leak and wreak havoc. Project Rebound offices were strategically placed in Gulf Shores and Bayou La Batre, and staff employed outreach and community mental health strategies to reach out to those impacted.

Although there are a number of services that Project Rebound employees can provide, these services are only as helpful as the degree to which prospective clients will accept and participate in them. Stigma often gets in the way. The stigma attached to mental illness and the idea of receiving mental health services carries numerous negative consequences for those who are stigmatized. Lack of employment opportunities (Overton & Medina, 2008), difficulty finding suitable housing (Link & Phelan, 2001), restricted social life (Perlick et al., 2001), and a negative self-concept (Link & Phelan, 2001; Watson, Corrigan, Larson, & Sells, 2007) are major barriers that impact a person's life. Essentially, once a person is diagnosed with a mental illness, others tend to view and treat the person differently, known as public stigma (Corrigan, 2005). As a result, it is common for the individual to begin viewing himself or herself negatively (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). The amount of stigma experienced is so powerful that some clients report it is more debilitating than the illness itself (Wilkinson, n.d.). Stigma attached to seeking mental health services in rural areas presents an

additional roadblock and has been documented in the literature (Smalley et al., 2010). Jameson and Blank (2007) noted that because rural communities tend to be close knit where most residents know each other, those who need mental health services might be even more fearful that confidentiality would be compromised.

It is not uncommon for negative effects to be felt years after a disaster (Kessler et al., 2008; Whaley, 2009). This study was conducted shortly after the one-year anniversary of the oil spill. Researchers were interested in exploring the degree of stigma related to people in the community seeking services, particularly mental health services. One could reasonably argue that because so many people living in the Gulf Region were affected by the oil spill, regardless of socioeconomic status, this could buffer against the extent of stigma attached to seeking services. In other words, the sheer number of people impacted could help to normalize the help-seeking behavior of those in the community, essentially a “We’re all in this together” mindset. Indeed Benight and McFarlane (2007) argue for more disaster research to explore the connection between the impact at the individual versus community level. So the question remains, is the community uniquely impacted or is the effect on the community simply an additive function of all individual responses? One methodological concern regarding stigma research is that too often social scientist experts study stigma-related theories and concepts far removed from the actual clients living with stigma (Link & Phelan, 2001). Thus, a lack of qualitative research exists to capture the voice of mental health clients. In the current study, researchers interviewed the mental health professionals who worked directly with the clients. Although it certainly would have been beneficial to interview the clients themselves, cultural barriers prevented direct access to clients as focus group participants.

Methodology

Data Collection Techniques

Purposeful sampling techniques were utilized to identify mental health professionals working in the Gulf Coast Region to participate in seven focus groups. Selection criterion required that participants were mental health professionals employed by or working in collaboration with Project Rebound to provide services to individuals and families impacted by the Gulf oil spill in Gulf Shores or Bayou La Batre, Alabama. Focus group locations were Project Rebound offices in the respective communities and associated schools. All participants self-identified as at least 19 years old (the age of consent in Alabama) and were served lunch or breakfast as an incentive. This study was approved by the university’s Institutional Review Board for protection of human subjects. Participation in the study was contingent upon standard informed consent protocol.

Focus group questions varied slightly across target populations (i.e., school counselors, outreach staff, home office staff), but all were similarly related to the key issues under study. Twelve questions were developed by the researchers to illicit information about delivery and utilization of mental health services related to the Gulf oil spill. Questions were divided into three sections (a) defining the disaster and recovery efforts [four questions], (b) identification of people in need and service delivery [four questions], and (c) challenges and needs for future disasters [four questions]. For example, one of the questions was: *Have you heard any clients*

talk about stigma related to mental illness or seeking help? This question had two follow-up questions, one related to shame and embarrassment and another related to the source of the stigma. All 12 questions were explored during seven semi-structured focus groups led by the two researchers. One investigator led the discussion and the other recorded the responses and took notes. Each focus group lasted from 60 to 90 minutes and was audio taped (with participant consent) and transcribed. A total of seven focus groups were held. Three focus groups (two with Project Rebound staff and one with school counselors) were held in Gulf Shores, Alabama with a total of 13 participants. Four focus groups (three with Project Rebound Staff and one with school counselors) were held in Bayou La Batre, Alabama with a total of eight participants. Each participant attended only one focus group, and there were at least two participants in each group.

Participants

There were a total of 21 participants; 17 mental health clinicians employed by Project Rebound and four school counselors from two school districts on the Gulf Coast of Alabama were interviewed. Eight participants served the Bayou La Batre community, and 13 served the Gulf Shores area. Overall, participants were Caucasian (Bayou La Batre, 57%; Gulf Shores, 77%), female (Bayou La Batre, 54%; Gulf Shores, 75%), and had at least a bachelor's degree (Bayou La Batre, 63%; Gulf Shores, 92%). The average age of participants was 40 in Bayou La Batre and 52 in Gulf Shores. The majority had worked in the mental health field at least 10 years, (Bayou La Batre, 100%; Gulf Shores, 69%) and several had assisted with at least one prior disaster (Bayou La Batre, 33%; Gulf Shores, 73%).

Coding and Analysis

Documented notes of the audio recordings of the focus groups were carefully reviewed and resulting data was analyzed using Glaser and Strauss' (1967) constant comparative method. There were no prior hypotheses, and the researchers used an open coding system to identify emerging themes. The data was analyzed by multiple coders. There were two coders for each transcript; both are authors of this paper. The transcripts were read multiple times, analyzed and then analyzed across transcripts. Open coding allowed categories of findings to emerge from the data. One theme that continued to emerge was related to stigma of help-seeking behavior. Specifically, the data revealed themes around (a) no visible damage, (b) cosmetic at the community level, (c) self-stigma, (d) public stigma, (e) labeling, (f) basic needs before mental health needs, (g) needing someone to listen, (h) exacerbated existing mental health needs, (i) cultural implications for mental health services, and (j) impact in the schools.

Results

No Visible Damage

There were numerous barriers discovered by the Project Rebound employees as they ventured out into the communities of Gulf Shores and Bayou La Batre and the surrounding areas. The inability to visibly detect damage and therefore determine who needed assistance was a hurdle.

With a hurricane, you see a neighbor's house down and my house is down so everybody's in a bad boat but there's no visible destruction [with the oil spill] and I don't know that my neighbor is as bad off as me.

During (Hurricane) Katrina they get out and clear the street and do all the reconstruction stuff—look what's going on in North Alabama right now. That didn't happen here; it couldn't happen here because of the difference in the disaster.

I do because there is not a lot of physical evidence as in a tornado when there are a lot of things torn down and a lot of debris—this is a silent disaster.

The difficulty detecting who needed assistance was not only a hurdle for clinicians in the delivery of services but also left many Gulf Coast residents isolated. This unique disaster caused confusion in terms of victim identification, which caused both internal and community conflict among residents who were in great need but lacked any outward sign. With no outward signs of need, many residents found themselves suffering alone. The increased isolation, yet far reaching effects of this disaster, led clinicians to employ creative methods of identifying individuals in need through innovative mental health outreach. Once clinicians began to identify individuals in need, they reported that the residents were very hesitant about seeking and receiving services, especially mental health services.

Cosmetic at the Community Level

Clinicians described the pristine appearance of the beaches and the community as not indicative of how people living in the Gulf were actually functioning. Although the town of Bayou La Batre was not a tourist destination, those who lived and worked in the town helped to feed the tourists. Because tourism rebounded very slowly, the effects trickled down to the people of Bayou La Batre. Services offered by local mental health and social service agencies were not greatly publicized because they would not appeal to tourists. Consequently, by not providing an accurate portrayal of how local residents were adjusting, it was more difficult to advocate for increased funding at the local, state, and federal levels.

I think this is not unusual necessarily for tourist kinds of communities anyway um I remember um you know uh I lived in South Florida and it was not unusual down there either. They really don't want social service agencies visible . . . you know I mean they're here to entertain people.

And there's even certain communities that won't even admit that any of the citizens there are even having problems and won't even admit they're problems . . . suicides and things going on but we don't need any help.

Particularly in Gulf Shores which relies heavily on tourism, the tendency was for the community to minimize the damage to the beaches in order to appeal to potential tourists thereby salvaging a dismal tourist season. However, the end result at the individual level was that of confusion and frustration.

Everything is good, we're, we're doing well, you know the spill is being contained, you know, come on in, you know come on over and take a look at our beaches how wonderful, we're open for business that's one of the things and yet on the other hand we're getting daily reports of well we tried you know attempt #27 to cap this thing and it's not happening.

[People] were like confused about well are we good or are we really bad?

Self-stigma

Clinicians identified many feelings and emotions such as pride, embarrassment, and shame that inhibited clients from seeking services and added to their uncomfortable feelings and lack of familiarity with needing assistance. Essentially, clients perceived themselves as “less than” if they needed assistance from others. This also applied to both basic services, such as food and utility assistance, as well as mental health services. Watson and colleagues (2007) noted that people buy into the stigma attached to receiving mental health services, and they begin to internalize what this means about them as a person consequently affecting their self-esteem and self-efficacy.

Resilient/self-reliant. Benight and McFarlane (2007) reiterated the common thread of resilience often present in disaster research and noted that discrepancies existed regarding the definition of this construct which ranged from healthy functioning across time to a person underestimating one's ability to cope post disaster. Fothergill's (2003) longitudinal study of women who survived the 1997 flood in Grand Forks, ND revealed that participants considered themselves independent, self-reliant, and felt more confident in their ability to deal with the flood based on past experiences with harsh weather conditions. Participants in the current study stated that clients had likewise been exposed to several past hurricanes and felt less concerned about this disaster albeit a different type of disaster. Thus, even though this disaster differed from previous disasters in the Gulf Region such as hurricanes, people in Mobile and Baldwin counties felt confident in their ability to cope with the oil spill based on their ability to successfully adapt to past disasters.

The people of Baldwin County are very resilient cause we've had lots of storms in life.

They're very self-reliant, they're very self-sufficient and they're thinking, like, well during that storm, if I survived that uh I can do this and this is not a big deal.

And that's what our problems are. You know people here, they're mostly uh self-made people, they're extraordinarily uh self-resilient and um I've been to other places where if people needed help, they're pretty good about crying out for help. These people here because of their peculiar you know points of view, if they ask for help, it's generally too late you know because they're holding on and they're saying, “No, we, can do this, we'll figure out a way.”

They're self-reliant, you know uh self-made uh old school uh it's ok for others to ask for help but it's not ok for them.

I think another aspect had to do with your local culture which has been that you take care of yourself.

They had done everything they knew to do uh to be resourceful, first.

Pride. In addition to self-reliant ideals and resiliency, the notion of pride seemed to be a significant barrier to those seeking services. So even though residents knew of available resources that could potentially help their respective situations, pride was often a powerful roadblock that inhibited their ability to accept services.

Men tend to be more prideful about taking help—both ways.

. . . others are prideful.

This is a prideful, hardworking blue collar community and so that is a huge hurdle to get over.

There is a lot of pride within the community and people not knowing about resources. Getting information out is one thing, having people accept it, like boat owners who have owned their boats since they were a kid it is hard for them to accept help much less counseling, when they probably do need it.

Pride. They're scared, prideful, and they don't know who to turn to.

Shame/embarrassment. Another reason that residents did not seek services after the oil spill was shame and embarrassment. According to the clinicians, the shame seemed to be centered around feelings of failure to provide for the family. The failure to provide and the resulting need for services was a new experience for many of the residents and was often the topic of conversation when working with Project Rebound clinicians. This degree of shame and embarrassment could also be connected to the sub-theme of self-reliance. In general, families believed that if they had been able to adequately navigate past disasters, this one would be no different.

It's a, it's a personal failure.

And there's more embarrassment. People don't wanna talk about it um people who've never had to ask for help before . . . um it's very, very humiliating for them, and that's part of what we try to do is to tell them don't be embarrassed.

There is concern among a lot of people about those being concerned about mental health and embarrassed to in fact become a part of their services.

A significant number (of people) who are a little bit hesitant to cross over that line and say well I need to go to that mental health center.

Then people who've been self-sufficient and been in an income bracket where they don't even know how to apply for food stamps. Do you know how humiliating for them it is to go and apply for food stamps?

Unfamiliar territory. Clients expressed to the Project Rebound clinicians that they never had to ask for help before the oil spill and that they were the ones who donated to help others in times of need. These individuals with little to no prior experience with receiving any type of assistance found themselves in a very unfamiliar place.

Because she was independent she always never had to depend on anyone to help her and stuff, and we get a lot of people like that.

I've heard it a hundred times, everybody else says it too, "I've worked all my life, I've paid all my taxes, I've done without, I've never before had to do this."

And then there are the people that have been fine all of their lives and all of a sudden this is it. They're not used to asking for help because they've been doing just fine.

These are the people that would go to the church and donate their clothes and donate canned food and now, I mean, talk about a blow to your self-reliance and like because it's kind of like, "I'm not good enough. I'm working this hard and still not working."

The people that are asking for help are the people that were donating to help other people.

And the wealthy folks of course, and this is not unusual, all of a sudden they realized that this was happening to them too.

Public Stigma

Few studies have examined public stigma as it relates to disaster mental health. In one such study, Fothergill (2003) found that, among women who survived a flood, participants were concerned about what others may think about them for receiving food stamps. Participants also made a point to remind others that their post-disaster financial situation was not reflective of their lives before the disaster. In the present study, there was a similar finding. Clients expressed concern over how others would view them if they needed services. Specifically, clients worried about the perception of neighbors related to seeking general assistance as well as mental health needs. Clients also did not see themselves as the type of people who would ever need help from others.

. . . I don't know that my neighbor is as bad off as me and I'm certainly not gonna tell them. I never wanna talk to them so they're both hurtin' but they're reluctant to come out.

A next door neighbor took her (neighbor) to Wal-Mart that day but didn't know that she had called us and pretty much it was a suicide crisis you know call. So that's the kind of situation, it's like even the neighbor didn't even know the situation but after that incident, he knows and now it's, it's for the better but that was very interesting to me that she borrowed the neighbor's phone (to call in crisis).

Like I do not want to be there because people are looking at me differently because I needed help and money to support my family.

They want no part of it [help] and they associate this kind of help with a certain set of people.

Labeling

Several clinicians in both Bayou La Batre and Gulf Shores described people in the community expressing concern about various labels connected with receiving mental health services. Potential consumers feared being labeled “crazy,” interacting with a therapist or counselor, and feared that friends and family in their local communities would become aware that they were engaged in services.

Am I crazy? Some clients explicitly referenced the word “crazy” and implied that is what a person would be if he or she received services from a mental health professional. In a study of African American church pastors in Southern Mississippi, several participants noted that members of their congregation post-Hurricane Katrina expressed concern about the possibility of being labeled “crazy” if they sought mental health services (Aten et al., 2010). This was echoed by Corrigan (2007) who noted that people may avoid mental health services in order to avoid being labeled as having a mental illness. The implications were obvious: people who needed services either delayed getting the help they needed or never sought the help which likely exacerbated their condition.

. . . there's still, there's certainly still a stigma with you know asking for mental health treatment, I mean their care um you know and I mean it's still very much there you know so you know they, uh “I'm not crazy” you know and “I'm just having some problems” you know, “I'm not crazy.”

(mental health professionals) are gonna label me crazy, put me in the hospital, no, no, no.

I even had one young man say to me at the end of the session, he said, “Boy it's good to know I'm not crazy.”

Clinicians used the clients' language in order to build empathy and lessen the stigma attached to seeking services.

I always tell them hey this doesn't mean that you're crazy you know, you need a little bit more than we can give you right now you know and that, that kind of works.

Therapist/counselor label. Clinicians in both communities stated that they quickly learned not to identify themselves as a “therapist” or “counselor” because they knew it would not be well received by prospective clients. Clinicians framed the interaction with clients as “talking,” and built trust with clients. The clinicians knew that there was no stigma attached to simply *talking* with clients. This approach kept the clients further engaged in the interaction and ultimately led to the clinicians being able to provide additional services.

When I do outreach or go to the community events that is one thing, but if I mention I am a therapist they actually stop talking about needing anything.

People coming in, not a lot of acknowledgment that they are getting counseling, it will be, “I am getting help for . . .” That is how they get around that. There is definitely stigma related to it as to be expected.

And you quickly learn to not say, oh I’m a mental health counselor, you know, do you need some counseling? No, we’re not doing counseling, we’re just talking, we’re just talking.

Yeah it’s not really counseling, it’s talking but there appears to be a huge stigma here.

Mental health client label. Some clients expressed great concern over the possibility of their friends and family spotting them interacting with a Project Rebound employee, and realizing they were seeking services, namely mental health. Clients went to great length—literally and figuratively—to avoid the label of “mental health client.” Some drove a considerable distance from their residence and bypassed other mental health providers on the way to lessen the chance that they might be seen receiving mental health services. Others would not give their name or write on the sign-in sheet that they were there to see a therapist.

I had this young man, about 32, he called said he’d never been, he’d never spoken to anyone about anything, my first session with him, we actually met in a library because he didn’t even want to meet or be around his home or business.

There was a guy who would not even tell me his name because he did not want it out, he drove a long way to get to our office. He would not sign in that he wanted to talk to a therapist. He had no one to talk to, he was very depressed. He said his family would make fun of him (if he was receiving mental health services) and that he did make fun of the situation when it first hit a year ago and Project Rebound was being announced. He said he was sitting around drinking with friends and said why anyone would need counseling for this . . . now a year later he said he needs it.

People will come [from long distances] to do their intake over here because they don’t want family or friends to know because this community—they know everything about each other, they know what time they get home, everything.

There is a senior program at the community center where I used to work and there was a [client] who was bipolar and sees the therapist regularly. So, that senior program, I saw them every day, and she had a manic episode when I was there. So the program leader asked me to come talk with her to calm her down. The next day, every one of the senior program people came by and was laughing to me about the situation. I don't want to say it was horrible, but at least 15-20 of them, the old ladies came by to ask me what happened with her and ask me, and they, they had smiles on their faces—"I can't believe she was yelling and screaming." So there is that—I think the fear of everyone knowing that you do things.

Basic Needs Before Mental Health Needs

Clinicians were well aware that if a person's basic needs were not met then he or she would not be receptive of emotional or higher-level needs. This natural progression from basic needs to more emotional needs was consistent with the well-established model of Maslow's Hierarchy of Needs (Maslow, 1968). In an overview of the principles of Psychological First Aid (PFA), Vernberg and colleagues (2008) reiterated the practicality of addressing basic needs before psychological issues can be addressed, which was reconfirmed by the Project Rebound clinicians.

Started with basic needs but turned into behavioral needs.

We had to meet basic needs before we could even touch their mental needs. So the first thing we do is, the first thing I do, is take care of their immediate needs and then down the line get into the other part.

(One client) needed some mental health first but I knew what needed to come first, her basic needs, you know, so we got her that and then we set up her appointment.

Some clinicians also framed the need to meet clients' basic needs in terms of building trust. Thus, if clients could trust the clinicians to bring them food then the clients would likely trust the clinicians enough to open up about how they were dealing with the effects of the oil spill.

They do 50 lb. boxes of food and we would deliver it and if you do that a couple of times, they start talking and then they invite you in.

(Our colleague) says if I can get them immediate access with food they are going to be more comfortable speaking with me and if I can help them immediately with something then I am going to be able to call on them.

Needing Someone to Listen

Clients expressed to the Project Rebound employees a need to be heard and listened to. It was as if they just needed someone to be a good listener and let them know that their reactions were normal. Whaley's (2009) study of Hurricane Katrina survivors revealed that they largely needed to have their feelings normalized although certainly some reactions were indicative of more clinically significant psychopathology. In the present study, the unfortunate, ironic tradeoff people apparently made was that fear of what others thought of them for needing mental health services limited their ability to vent to friends and family and compounded their stress level.

A lot of people just need to have their voice heard.

And what I find is that they're so thankful that they finally have someone they can talk to. And we listen.

. . . just want someone to help them, they are at their emotional wits end but a few are crying on me and just by talking it out they calm down, they think they are all alone.

A lot of people are naturally stressed because they cannot find work and are not financially stable . . . just like a situational depression but they need someone to listen to them.

Some . . . were so distraught or you know how you cannot concentrate or so they are like I am depressed or maybe I do need to talk to somebody so it kinda gets to where they do not even have time to think about it—they just need someone to talk to.

For the first 40–45 minutes, he just cried, did not say a word. Cried. To a complete stranger . . . and that wound up being a two and a half hour session but um he just said I don't know how to tell people how I'm feeling, I don't know how to do this and if that gives you an idea, he just, he just cried.

When they finally are willing to admit help . . . we sit down and talk to them and as we're talking with them they just dump because catharsis—just to feel comfortable that they can have somebody who shows that they care and they're listening.

Exacerbated Existing Mental Health Needs

For a subgroup of individuals who received services from Project Rebound, mental health services were already needed, and the effects of the oil spill exacerbated their current struggles. Perhaps not surprisingly, the impact of pre-existing mental health conditions have been shown to relate to coping responses after a traumatic event ranging from PTSD symptoms and pregnancy loss (Engelhard, van den Hout, & Kindt, 2003) to depression after earthquakes (Knight, Gatz, Heller, & Bengtson, 2000). Residents of the Gulf Coast were no different and

Project Rebound clinicians acknowledged the vulnerable situation many of their clients were in before the oil spill and their decline in the aftermath.

They were chronically living on the edge prior to the economy cutting down, but not so much so and then uh the oil spill came along and that escalated that.

We're seeing people that have some sort of a diagnosis of a mental health issue that was kinda, sorta managed before. Now it's just rampant. If you had somebody with a mild depressive disorder, if there is such a thing, well now it's worse. And now we're seeing . . . they were functional in some way, they lost their job, they lost their insurance, it was just, it's just crazy. I would say 70% of all these people had some sort of mental health issue and this whole thing has just exacerbated the whole thing to the point where it's completely over the top.

I mean hell by the time we get to them, they're like, "I need help now, yesterday. I'm losing my home, I'm losing my kids, you know."

People are worn so thin and they have put us off for so long . . . the problem is that they are further gone than the beginning and the intervention we could have started months ago won't really help them now and they are needing more serious assistance.

Cultural Implications for Mental Health Services

Despite being adjacent counties that border the Gulf of Mexico in the state of Alabama, the demographics of Mobile County and Baldwin County as well as the industries that support their local economy are quite different. Some of these differences are apparent in the local culture and consequently their beliefs about seeking mental health services. The stark contrast between the cultural beliefs held by members of these two counties is further evidence of the need to tailor interventions and outreach efforts accordingly (Benight & McFarlane, 2007; Ginsberg, 2005; Rosen, Greene, Young, & Norris, 2010). In a sample of children and adolescents relocating from Louisiana to Texas after Hurricane Katrina, authors noted that coping strategies were impacted by cultural stereotypes and differences in language (Pfefferbaum et al., 2008). Project Rebound employees in Bayou La Batre knew that people in the community were struggling, but their attempts to help were initially met with resistance due to cultural and religious beliefs which denounced the need for intervention. The effects of stigma in this community were further compounded by the locals' need to reject services to preserve their spiritual well-being. This presented another obstacle for clinicians who reached out to provide much needed assistance. Watson and Ruzek (2009) noted that there is a general lack of rigorous science devoted to disaster mental health on which to base proper services. This was evident in the current study where at times clinicians essentially learned by trial and error—what worked in the neighboring county simply did not work in theirs.

And . . . we need more recognition of cultural differences and the need for help on our end all the way up.

Culturally, in the Asian culture they do not think of mental problems as help they need. They would not go to (the local mental health center) for assistance because they kind of deny that that is part of our culture that we do not have that.

They are not coming to us with their mental health needs for one the Asian community does not recognize mental health, this is just a phase you go through in the Buddhist world. So we have that aspect to fight against and then you have, "There is nothing wrong with me, I just need a job. I don't have any issues, I don't have problems at home, I am just frustrated because I need a job, I need money to pay my bills!"

We offer parenting skills, and parent stress management, etc . . . for parents but they do not come nor are utilized. They still view it as a mental illness. Cannot mention that—we handle our own here!

We have a large Asian community, and Hispanic, and different culture systems and the Asian and Buddhist religion is that we have to suffer through what we go through now so that we can have a better life next go around. You try beating that—you try taking away what they see as their salvation. I am offering help, let us help take away your suffering and they look at you like you are crazy—I cannot give up my suffering—I have to get through this and my next life will be better. I mean, we are Satan to those folks.

How to reach clients. Although knocking on doors out in the community worked in adjacent Baldwin County, it was not a successful means of reaching out to those in need in Bayou La Batre. Clinicians networked with community leaders, those who were trusted by the locals. Therefore, Project Rebound employees ventured out into non-traditional therapeutic settings in order to find those in need. A well-respected member of the community was added to the Project Rebound staff, and this increased trust among those who needed services. Silove, Steel, and Psychol (2006) cautioned against an overemphasis on outside help versus utilizing individuals and services already present in the communities affected. In the present study, collaboration with key figures in the community demonstrated to the people that they could largely help themselves with minimal guidance from outsiders—a much more empowering approach. Likewise, Rosen and colleagues (2010) recommended that disaster mental health organizations hire a diverse staff to better meet the needs of the communities being served.

When we first got started we went knocking on doors and it didn't work. So we set up at the community center—they have a lot, a lot of people who come in and out of the community center.

(local business leaders, Red Cross) all said we needed to go to the docks because those dock workers, that is where they do the clean-up crew, that is where the seafood workers come in and out, that is who you need to talk to because they are having a really hard time. So, for about two months every day at 5:50 I was out on the docks, shaking hands, meeting people, introducing

myself to the same folks until, I would bring donuts. It sounds silly but it was those little things that lead to, "Oh hey, Miss W," and they knew me and I was like, "Come see me at the community center."

. . . we got chased off properties—it was really interesting. What we did learn was that we were not going to get very far knocking on doors. So we regrouped.

Ms. L who is very well known in the area and she worked with head start and all the Vietnamese and the Asian communities they knew Ms. L and so it was really nice for her to be able to bring those people in and offer services.

Absolutely! That is one of the things that the team lead touched on. We went to the natural leaders in the community. We went to a lot of the church leaders—"Do you recognize any one in the congregation that might need your help?" and they said "yes" and they referred a lot of people to us.

These people were like, "I don't know you, but my pastor thinks I should talk to you."

Bayou La Batre was strategically chosen as one of the sites for a Project Rebound office because the staff knew that the locals would not likely go to another community for assistance, regardless of the services offered.

They will not go to Mobile but will go to the Bayou.

Those specific locations were chosen for that reason—trust and utilization in the community. They will go where they feel comfortable.

The idea for some of our parents that they could go right down the road here, because the whole thing overwhelmed them anyway—just right down here in the Bayou, it's close, you can see someone that—it made it more comfortable for them to attempt it.

Impact in the Schools

The effects of the oil spill were felt not only among adults and parents within families, but also and perhaps not surprisingly, trickled down to children. Across all levels of education in the school system, these effects manifested as anger, bullying, and even suicide. School counselors described their efforts to improve communication with parents by building trust with the students first and also, when time and their schedule permits, visiting families in the home. Counselors learned that programs and services aimed at helping students and families were not well attended if they were held at the school.

Strengthening the home-school link. School counselors described their efforts working with the parents of the students, and trust built with the students led to trust with the parents.

In our community, sometimes they won't reach out, but they will for the kids.

[Parents will say] I don't know you but my child said they have seen you at their school.

Services provided to parents in the home were more effective and led to increased participation as opposed to services held at school.

We also have a parenting program through mental health which parenting is something probably that could really help because and it's a parenting program that they actually go to the home and they work with parents maybe for eight weeks and um so they can target on the specific needs of each family and that's through the grant. If you have a parenting class here, they don't come.

Suicide. School counselors described the ultimate consequences of stress related to the oil spill, suicide. News reports from numerous media outlets covered the story of a well-respected charter fishing boat captain who was married with a family and ultimately took his life, likely due to ongoing stress and anxiety, and bureaucratic hassles related to reimbursement after the oil spill (Hedgpeth & Fahrenthold, 2010). This tragic event, and the amount of attention that it received, sparked a discussion about the mental health of those living in the Gulf.

I guess that the suicide of the boat captain was what started the whole thing. That got media attention. That was one of the first things that got media attention on the mental health side.

We have had a former parent (of a student) who committed suicide over the oil spill.

We haven't had uh suicide of a student at the elementary but we have had one at the middle school before.

Well at (a local high school) wow I mean they had three even like two teachers right? . . . two teachers and a student.

. . . there are a lot of children that their actions and reactions at school related to situation issues at home and when they come in to see us and they think they are coming to bring the child and the next thing you know the parents are in therapy and the kids are great.

Discussion

Whaley (2009) stated that because there is clear evidence that psychological distress does often result post-disaster, there needs to be careful planning of mental health services in preparation for future disasters in communities. This is especially important when working and planning for disaster in rural communities. As experienced by the clinicians in this study, their innovations and community collaborations allowed for extensive service delivery in an

otherwise challenging situation. When planning for future disasters, the experience of the Gulf Coast Project Rebound staff is invaluable, and rural social workers and other helping professionals would be advised to take note paying specific attention to how stigma influences service delivery.

Clinicians in the Alabama Gulf Coast communities experienced a number of stigma-related barriers to delivering services including self-stigma, public stigma, and cultural implications of seeking and receiving aid. These experiences are not unique to the Alabama coast or the Gulf oil spill. Fothergill (2003) reported similar findings in the women of Grand Forks, ND after a devastating flood. The women reported feeling humiliated because they accepted charity after the disaster. The very act of accepting help challenged the women's views of who they were in the community: middle-class and self-sufficient. The women viewed the culture of their small town as hard-working and traditional, a place where people made their own way. Project Rebound clinicians reported multiple instances where individuals seeking aid after the oil spill felt almost shocked and ashamed at their current circumstances. In addition, clinicians found individuals hesitant to seek services because they were proud, and had always viewed themselves as the givers, not takers. This self-stigma led to a delay in services until, as the clinicians stated, it was a major crisis and there was nowhere else to turn.

In addition to self-stigma, public stigma served as a barrier to services for the Gulf Coast residents. Project Rebound clinicians quickly learned to not mention the "Stigma of Help-Seeking Behavior Following the Deepwater Horizon Oil Spill" of counselor/therapist or any reference to mental health services until after they had an established relationship with the clients. To counter the public stigma and identify potential clients, Project Rebound staff worked as resource brokers first, providing connections to food pantries and utility assistance before approaching emotional and psychological issues. This approach mirrors the theory of psychological first aid which states that individuals' primary need during the aftermath of a disaster is safety and security (Vernberg et al., 2008). As rural communities prepare for disaster it would be wise to take notice of the community pride and possible stigma related to seeking and receiving help.

However, even the promise of basic needs may not be enough to breach some cultural barriers. Project Rebound staff found that cultural beliefs in which seeking services would be viewed as an abomination was one of their biggest challenges. To combat this challenge, the staff identified community leaders and employed individuals with the same cultural background and beliefs to serve as liaisons to those in need. In addition to hiring community leaders, the staff employed non-traditional, yet culturally appropriate, mental health outreach techniques which led to successful and effective service delivery. If front line responders can identify the possible cultural implications of seeking and receiving help before disaster strikes they could invite community leaders in advance and, in turn, expedite services while preventing frustration and providing help. The Project Rebound clinicians were able to provide services after the Gulf oil spill in rural, close-knit communities by employing a variety of outreach techniques and offering an assortment of services. It was only through their collaborations, integration of community leaders, and persistence that clinicians were able to intervene with a traditionally closed community. As other rural communities begin to prepare for future disasters, they can

integrate five lessons from the Project Rebound staff and the Gulf oil spill experience which correlate with the recommendations from Sundet and Mermelstein's (1997) research after the Great Flood of 1993.

1. Identify key community services in advance and have a plan to work together to offer coordinated and efficient services. This will reduce the feelings of self and public stigma of people needing to go to multiple sites in order to meet needs. Sundet and Mermelstein's (1997) research provided a similar recommendation encouraging communities to build coalitions before disasters strike. They state that human service coalition building can not only help aid in the delivery of resources prior to disasters, but can enhance the efficiency and effectiveness of disaster response.
2. Identify the community members most at-risk in different types of disasters and have a plan on how to approach them. If responders know who might be most impacted (i.e., those who are already on the edge, financially, emotionally, etc.), they can better anticipate needs and create appropriate plans. Sundet and Mermelstein (1997) encourage communities to plan for a variety of disasters in advance and get to know the appropriate resources.
3. Identify and become familiar with all the cultures and differences within the community. Although the Project Rebound staff knew that there were large differences in culture among their residents, they had not previously explored those differences and contemplated how the differences might impact disaster relief services. Sundet and Mermelstein (1997) recommended that communities educate each other on mutual support. In order for communities to engage in mutual support they must first gain an awareness of and respect for cultural differences, and view these differences as strengths contributing to solutions rather than deficits perpetuating the problems (Ginsberg, 1976).
4. Bring key stakeholders to the planning table. Make sure there are representatives, preferably respected leaders and/or community members, from all segments of the community at the disaster planning table. Sundet and Mermelstein (1997) also recommended that communities develop "linkages among critical leaders" (p. 67). Moreover, Putnam (1993) argued that a crucial component of mobilizing community resources in rural communities is the emphasis on building social capital. The Project Rebound staff found that outreach efforts were more successful once they employed the help of community leaders. This is especially important in communities with multiple languages and cultural practices that may differ from traditional Western approaches.
5. Do not forget the children—they feel the effects of disasters too. Project Rebound staff were effective in providing services through a number of strategies: They presented to businesses, community meetings, and worked closely with the school systems. The staff and school counselors found that the children were a vehicle to identify and provide services to families in need, which negated some of the initial stigma related to help seeking behavior. Overstreet, Salloum, Burch, and West

(2011) noted the prevalence of depression and PTSD in children post-disaster and echoed the need to reach affected children through school-based mental health services.

The five lessons mentioned above align closely with previous research regarding rural mental health services. Richgels and Sande (2009) noted the importance of collaboration in rural communities where resources are already typically scarce. This was evident in the current study. Because the disaster was unique in its nature and effects, practitioners quickly learned that the usual template for providing mental health services would not work. Creative approaches to connect with the communities were essential if residents were going to receive help. Similarly, cultural differences were manifested differently in Bayou La Batre and Gulf Shores. Collaborating with key stakeholders and those in the community who were well respected proved to be a critical element in reaching out to those in need. Project Rebound staff also utilized this experience and knowledge to help families by building rapport with their children first through the school system.

The excerpts and emerging themes from this study have yielded valuable information to better understand the intersection between rural communities, stigma, and a unique disaster; however, there was one potential limitation in the study and that is the issue of self-selection. Because investigators wanted to capture the voice of those mental health professionals working directly with people living in Alabama's rural coastal communities affected by the Gulf oil spill, the hope was that all involved practitioners would have an equal opportunity to participate in the focus groups. In fact, investigators communicated regularly with Project Rebound administrators to select an ideal time frame to conduct the study that would maximize the number of individuals who would be able to participate in the study. Although it was not known exactly how many people did not participate in the study, administrators reassured the authors that the majority of the Project Rebound staff were present during the focus groups. Moreover, it was believed that the clinicians who did not participate were absent largely because of client crises that took precedence over participation in the study.

The Deepwater Horizon oil spill was one of the worst disasters in U.S. history and devastated those living in the coastal communities of Alabama and surrounding areas. The two communities explored in this study, Gulf Shores and Bayou La Batre, AL, are very different in terms of demographics and economic dependence on the Gulf. Project Rebound clinicians and staff were dispatched to the area after the spill and had virtually no way of knowing what was waiting for them due to the unique nature of this disaster. This study aimed to provide guidance as to how communities and mental health professionals could prepare for such a disaster should it happen in the future. Although stigma of mental illness is not new, its role in deterring individuals from seeking services post-disaster is fairly new. A more proactive approach when planning for disasters coupled with a better understanding of stigma will be critical to ensure that the needs of communities will be properly addressed.

References

- Alomari, O. (2010). *A guide to Somali culture*. Columbus, OH: Ohio Department of Public Safety. Retrieved from <http://www.publicsafety.ohio.gov/links/HLS0075.pdf>
- Alston, M. (2007). It's really not easy to get help: Services to drought-affected families. *Australian Social Work, 60*(4), 421-435.
- Aron, L., Honberg, R., Duckworth, K., Kimball, A., Edgar, E., Carolla, B., & Fitzpatrick, M. (2009). *Grading the states 2009: A report on America's health care system for adults with serious mental illness*. Arlington, VA: National Alliance on Mental Illness.
- Aten, J. D., Topping, S., Denney, R. M., & Bayne, T. G. (2010). Collaborating with African American churches to overcome minority disaster mental health disparities: What mental health professionals can learn from Hurricane Katrina. *Professional Psychology: Research and Practice, 41*(2), 167-173.
- Benight, C. C., & McFarlane, A. C. (2007). Challenges for disaster research: Recommendations for planning and implementing disaster mental health studies. *Journal of Loss and Trauma: International Perspectives on Stress & Coping, 12*(5), 419-434.
- Brown, L. M., Rothman, M., & Norris, F. (2007). Issues in mental health care for older adults after disasters. *Generations, 31*(4), 21-26.
- Corrigan, P. W. (Ed.). (2005). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.
- Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work, 52*(1), 31-39.
- Daley, M. R., & Hickman, S. (2011). Dual relations and beyond: Understanding and addressing ethical challenges for rural social work. *Journal of Social Work Values and Ethics, 8*(1).
- Daly, E. S., Gulliver, S. B., Zimering, R. T., Knight, J., Kamholz, B. W., & Morissette, S. B. (2008). Disaster mental health workers responding to ground zero: One year later. *Journal of Traumatic Stress, 21*(2), 227-229.
- Dodds, S., & Nuehring, E. (1996). A primer for social work research on disaster. In C. L. Streeter & S. A. Murty (Eds.), *Research on social work and disasters* (pp. 27-56). New York: Haworth Press.
- Engelhard, I. M., van den Hout, M. A., & Kindt, M. (2003). The relationship between neuroticism, pre-traumatic stress, and post-traumatic stress: A prospective study. *Personality and Individual Differences, 35*(2), 381-388.

- Fothergill, A. (2003). The stigma of charity: Gender, class, and disaster assistance. *The Sociological Quarterly*, 44(4), 659-680.
- Ginsberg, L. H. (Ed.). (1976). *Social work in rural communities: A book of readings*. New York: Council on Social Work Education.
- Ginsberg, L. H. (Ed.). (2005). *Social workers in rural communities* (4th ed.). Alexandria, VA: Council on Social Work Education.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Piscataway, NJ: Aldine Transaction.
- Hedgpeth, D., & Fahrenthold, D. A. (2010, June 24). Apparent suicide by fishing boat captain underlines oil spill's emotional toll. *Washington Post*. Retrieved from <http://www.washingtonpost.com/wp-dyn/content/article/2010/06/23/AR2010062305361.html>
- Jameson, J. P., & Blank, M. B. (2007). The role of clinical psychology in rural mental health services: Defining problems and developing solutions. *Clinical Psychology: Science and Practice*, 14(3), 283-298.
- Kessler, R. C., Galea, S., Gruber, M. J., Sampson, N. A., Ursano, R. J., & Wessely, S. (2008). Trends in mental illness and suicidality after Hurricane Katrina. *Molecular Psychiatry*, 13, 374-384.
- Knight, B. G., Gatz, M., Heller, K., & Bengtson, V. L. (2000). Age and emotional response to the Northridge earthquake: A longitudinal analysis. *Psychology and Aging*, 15(4), 627-634.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
- Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, 52(12), 1621-1626.
- Maslow, A. H. (1968). *Toward a psychology of being*. New York: Van Nostrand Reinhold.
- Overstreet, S., Salloum, A., Burch, B., & West, J. (2011). Challenges associated with childhood exposure to severe natural disasters: Research review and clinical implications. *Journal of Child & Adolescent Trauma*, 4(1), 52-68.
- Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counseling and Development*, 86(2), 143-151.

- Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services, 52*(12), 1627-1632.
- Pfefferbaum, B., Houston, J. B., Wyche, K. F., Van Horn, R. L., Reyes, G., Jeon-Slaughter, H., & North, C. S. (2008). Children displaced by Hurricane Katrina: A focus group study. *Journal of Loss and Trauma: International Perspectives on Stress & Coping, 13*(4), 303-318.
- Putnam, R. D. (1993). The prosperous community: Social capital and public life. *The American Prospect, 13*, 35-42.
- Richgels, J., & Sande, C. (2009). Collaboration is key for rural challenges. *Policy & Practice, 67*(5) 17-19.
- Roberts, Y. H., Mitchell, M. J., Witman, M., & Taffaro, C. (2010). Mental health symptoms in youth affected by Hurricane Katrina. *Professional Psychology: Research and Practice, 41*(1), 10-18.
- Rosen, C. S., Greene, C. J., Young, H. E., & Norris, F. H. (2010). Tailoring disaster mental health services to diverse needs: An analysis of 36 crisis counseling projects. *Health & Social Work, 35*(3), 211-220.
- Safran, M. A., Mays, Jr., R. A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., . . . Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public Health, 99*(11), 1962-1966.
- Silove, D., Steel, Z., & Psychol, M. (2006). Understanding community psychosocial needs after disasters: Implications for mental health services. *Journal of Postgraduate Medicine, 52*(2), 121-125.
- Smalley, K. B., Yancey, C. T., Warren, J. C., Naufel, K., Ryan, R., & Pugh, J. L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology, 66*(5), 479-489.
- Sundet, P., & Mermelstein, J. (1997). Predictors of rural community survival after natural disaster. *Journal of Social Service Research, 22*(1-2), 57-70.
- U.S. Census Bureau. (2010). *Demographic profile highlights*. Washington, DC: Government Printing Office. Retrieved from <http://quickfacts.census.gov/qfd/states/01000.html>
- Vernberg, E. M., Steinberg, A. M., Jacobs, A. K., Brymer, M. J., Watson, P. J., Osofsky, J. D., . . . Ruzek, J. I. (2008). Innovations in disaster mental health: Psychological first aid. *Professional Psychology: Research and Practice, 39*(4), 381-388.

- Watson, A. C., Corrigan, P., Larson, J. E., & Sells, M. (2007). Self-stigma in people with mental illness. *Schizophrenia Bulletin*, 33(6), 1312-1318.
- Watson, P. J., & Ruzek, J. I. (2009). Academic/state/federal collaborations and the improvement of practices in disaster mental health services and evaluation. *Administration and Policy in Mental Health and Mental Health Services Research*, 36(3), 215-220.
- Whaley, A. L. (2009). Trauma among survivors of Hurricane Katrina: Considerations and recommendations for mental health care. *Journal of Loss and Trauma: International Perspectives on Stress & Coping*, 14(6), 459-476.
- Wilkinson, A. P. (n.d.). *We are more than our disorder*. Retrieved from National Empowerment Center website: http://www.power2u.org/articles/empower/our_disorder.html
- Zakour, M. J. (1997). Disaster research in social work. *Journal of Social Service Research*, 22(1-2), 7-25.

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