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Reports from the Front: The Effects of Hurricane Katrina on Mental Health Professionals in New Orleans

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Hurricane Katrina created an unprecedented mental health crisis in New Orleans. Once they could return to work, local mental health professionals attempted to treat survivors of the storm while dealing with the storm's impact on themselves. Those working in public settings were offered in-service training and supervision. But clinicians in private practice often found themselves bearing the brunt of posttraumatic uncertainty alone. The current paper includes four experiential reports from area clinicians describing their early struggles to maintain a sense of continuity in their ongoing clinical work, only to realize how much of the personal is also professional in the aftermath of a disaster of this magnitude, and how personal and professional inevitably inform one another when clinicians and patients survived similar dangers and losses. The introduction locates these four papers in the larger context of post-Katrina New Orleans and a program that was specifically tailored to meet the needs of local clinicians. This program demonstrated the ways in which psychoanalytic ideas can be used to give meaning to a traumatized mental health community's profound disorientation.

INTRODUCTION

> *"To be a therapist in the winter of 2005 was at once the hardest thing and the only thing possible." — Kathryn L. Nathan, Ph.D.*

Hurricane Katrina was one of the deadliest hurricanes in the history of the United States and the sixth strongest overall storm among recorded Atlantic hurricanes. As the National Hurricane

Center began warning of devastating damage and areas that would be uninhabitable for weeks, on August 28, 2005, the mayor of New Orleans issued

a mandatory evacuation order, the first such order in the city's history. The storm made landfall in southeast Louisiana on the following morning. It caused severe destruction along the Gulf Coast, but the most significant damage occurred in the city of New Orleans when the levee system catastrophically failed. Eventually 80% of the city and large tracts of neighboring parishes, or districts, were flooded; the floodwaters lingered for weeks. Failures at the local, state, and federal level compounded human suffering and lengthened the time that the city remained uninhabitable. In all, more than 1,836 people died during the storm and in its immediate aftermath (that is not counting those who died in the weeks and months afterward); 736 people remain unaccounted for; 275,000 homes were destroyed; 600,000 pets were killed or abandoned; 400,000 jobs were lost.

A mental health crisis of epidemic proportions followed in Hurricane Katrina's wake. Four years after the storm, epidemiologists established that in the greater New Orleans area anxiety, depression, and avoidance grew worse each year while intrusive thoughts and arousal decreased (Kessler et al., 2008). Suicidal ideation more than doubled from 3.1% five months after the storm to 7.9% two years later. In late 2009 the rate of completed suicides in New Orleans approached twice the national average (Barrow, 2009). This is the dangerous course that long-term stress reactions typically follow (Boulanger, 1985, 2007): Over time, without treatment, affected persons become more isolated and more avoidant.

In 2008, the New Orleans Birmingham Psychoanalytic Center was awarded a grant tailored to meet the needs and to describe the experiences of local clinicians in the years when the storm's psychological toll was at its worst and to place these needs and experiences in a psychoanalytic framework. The timing of this intervention was fortuitous. By and large the latency period that commonly follows a catastrophic trauma had run its course and the long-term psychological legacy of the storm was becoming clear even though most clinicians had few ways of conceptualizing it. Most psychological studies of communities that have survived disasters are conducted in the immediate aftermath, leaving epidemiologists and sociologists to study the long-term impact. Furthermore, it is of particular significance that this study targeted mental health clinicians, not the general population, and it is significant that it was sponsored by a psychoanalytic center intent on reaching out to the mental health community at large, a community that proved eager to be given ways of understanding ongoing reactions to the storm rather than being offered, and being asked to offer, mechanical solutions to individual symptoms.

The present paper, including four first-person reports from mental health professionals and the discussion that follows, placing the entire experience in a psychoanalytic frame, is one outcome of that intervention. It is, in effect, an account of the most resilient members of a mental health community that survived a disaster of epic proportions. The study offered an opportunity to think further about the dynamics of shared trauma and the ways in which psychoanalytic ideas can be used to give meaning to a traumatized mental health community's profound disorientation. Three years after Katrina, most local clinicians believed that they should have some understanding about the impact of the storm on themselves and on their patients, but many found they had not even begun to formulate the necessary questions.

What follows is a series of reports from clinicians in New Orleans who shared the aftermath of the hurricane with their patients. Each of these professionals describes her early struggles to maintain a sense of continuity in her ongoing clinical work only to realize how much of the personal is also professional in the aftermath of a disaster of this magnitude, and how

personal and professional inevitably inform one another when clinicians and patients survived similar dangers and losses. Openly and exquisitely, they show how clinicians work on the other side of the apocalyptic anxiety they had come to know intimately, the gut-level terror with which they came face-to-face after the storm. They provide clues about how it is possible to listen to patients' fears, even as one's own feelings of impermanence and uncertainty are so overwhelming.[1]

BACKGROUND: MENTAL HEALTH PROFESSIONALS AFTER KATRINA

The First Three Years After The Storm

Immediately after Hurricane Katrina, mental health volunteers flooded the area; some offered crisis counseling to those immediately affected, and others ran brief training groups for the first responders working with survivors. However, Joy Osofsky (personal communication, 2009) echoed the frequent complaint that there were too many people trying to help without any clear organizational structure. City, state, and federal programs were mobilized to provide psychological first aid and other essential interventions aimed at fostering resilience among the first responders and their families. The Osofskys

and their colleagues (Osofsky, 2008; Osofsky, Osofsky, Kronenberg, & Cross, 2009, Speir, Osofsky, & Osofsky, 2009) instituted programs to screen children and families, to coordinate efforts with the school system, and to refer survivors to treatment and other essential resources. However, the need for resources, for treatment, and for case management often overwhelmed the community's ability to meet those needs. Within 18 months, the volunteers had moved on to other more recent disasters.

Outsiders could not and should not be expected to provide the continuity of care that is imperative in a community struck by disaster. Yet, in the years following the storm, the number of mental health professionals in New Orleans sharply decreased. Some of those who had evacuated chose not to return. Others, having lost their patient base, opted for early retirement. A few took advantage of offers from other states to set up private practices far away from the uncertain circumstances in New Orleans. Between 2005 and 2007, Orleans and Jefferson parishes lost 35% of practitioners, and metropolitan New Orleans lost 85% of its psychiatrists (Faust, Black, Abrahams, Warner, & Bellando, 2008). The administrator of one not-for-profit clinic reported in 2008 that there had been a 75% turnover in clinical staff since the storm. In 2008 the number of psychiatric beds in New Orleans was drastically reduced, leaving the remaining clinicians to treat more acutely ill patients than they were accustomed to, often with less time for ongoing and less critical cases. The need for services was outstripping available resources.

[1] *The four papers that follow were presented at a conference organized to mark the fifth anniversary of the storm. In addition, one of us (Boulanger) conducted a series of interviews with mental health professionals about their lives and work in the wake of the disaster. The 40 respondents—psychiatrists, psychologists, social workers, marriage and family therapists, and pastoral counselors—represented a wide range of psychological approaches: psychodynamic therapy and psychoanalysis, family systems, neuropsychology, psychiatry, existential, CBT, DBT, and EMDR. Most of the interviews were conducted in person, many individually, some in groups, a few by telephone. All the interviews were recorded and transcribed. Initial interviews lasted from one hour to an hour and a half; follow up interviews generally lasted 45 minutes.*

Clinicians' Experiences During Katrina

Few mental health professionals remained in New Orleans during the hurricane; most heeded the mandatory evacuation order, expecting to return to their homes and their lives in a couple of days, as they had in the past. They were inundated not by floods but by news coverage as they followed the destruction of their city on television. A recent article in *American Psychologist* (Neria, DiGrande, & Adams, 2011) has justly questioned the idea that Americans watching the destruction of the World Trade Center on television would develop posttraumatic stress disorder. However, the exiled inhabitants of New Orleans —seeing images of desperate people marooned on highways they had traveled every day or watching dead bodies floating in familiar streets or abandoned by the receding waters—believed they were witnessing the destruction of their lives as they had known them. Some located their homes on Google Earth and watched flood waters surge over them. Most would not know for several weeks how much damage their homes and offices had sustained, if any. For many the damage was considerable.

Although they had learned through the media of the physical and moral unraveling of their community, many clinicians were not prepared for the destruction they encountered when the evacuation order was lifted after six weeks. They were startled by the presence of armed militia, discouraged by how few neighbors had returned, and by the fact that many familiar venues—stores, places of worship, restaurants, homes, and professional offices—had been abandoned. Several described an “apocalyptic wasteland, just like in McCarthy's novel *The Road*, with danger lurking around every corner.”

Impact on the Mental Health Community

On their return, mental health professionals working in public health settings and not-for-profit agencies or in hospitals and other government funded programs often had opportunities to debrief with a network of colleagues. Administrators ensured that in-service training and supervision or peer supervision were available, as Debbie Poitevant describes in one of the reports that follow. But clinicians in private practice often found themselves bearing the brunt of post traumatic uncertainty alone. By the winter of 2007–2008, a little more than two years after the storm, most mental health professionals had few supports and even fewer ways of understanding how to adjust to the long-term impact of the disaster on their work and in their lives. Many of the short-term solutions that had been offered gave temporary respite, but in the end they did

not address the ongoing sense of fragility and the radically altered sense of self that both the clinicians and their patients were contending with.

Preoccupied as they are with the physical job of recovery, adults often may not become aware of the price they have paid psychologically for their survival. It is not unusual for the consequences of an adult onset trauma to take a month, or a year, or even several years to present themselves. Local clinicians spoke of this phenomenon as a manifestation of Maslow's Hierarchy of Needs, they described it variously as “trauma's slow burn,” and “our pioneering spirit.” Thus, the sense of anomie came into particularly sharp focus as life took on a semblance of regularity, if not normality. Homes were rebuilt, practices relocated, schools reopened, professional organizations established new routines, the downtown area was being renovated, husbands and wives had found new jobs. Yet every one of the psychotherapists interviewed about the storm

and its aftereffects was painfully aware that things would never be the same again; a sense of precariousness had invaded their lives and their patients' lives. They feared that their psyches had been changed forever.

Without understanding the long reach of adult onset trauma (Boulanger, 2007), clinicians expected themselves and their patients to have surmounted their losses. Many described feeling ashamed, fearful, and confused when they continued to be so deeply affected by the storm's aftermath, many agreed that the shattering of everyday life had resulted in what felt like a collapse of individual selves, the loss of essential ego strengths. Those who had evacuated and recovered their homes believed that they had no excuse to feel badly, those who had lost their homes pointed to others who had sustained greater losses, survivor guilt compounded the shame and added to the growing sense of isolation.

Complicating the personal impact of the storm was the loss of community, which is rarely given sufficient psychological weight when survivors are treated individually. A traumatized community is more than an assembly of traumatized persons; “sometimes the tissues of the community can be damaged in the same way as the tissues of the mind and body” (Erikson, 1976). A damaged community cannot sustain its inhabitants as they grapple with their individual losses. With the changed face of New Orleans, the sense of uncertainty, the friends who left, professional associations that no longer met, the routines that had been disrupted—everything that was familiar had been swept away. “People have,” as one clinician put it, “lost their navigational equipment, as it

were, both their inner compasses and their outer maps." Along with individual losses, the comfort of belonging to a larger group had been disrupted.

In this climate in post-Katrina New Orleans, a vicious cycle took hold in which clinicians were troubled by their own failure to have made a full recovery from the effects of the storm and deeply concerned that their patients continued to suffer these effects as well. Embarrassed by what they took to be personal and professional shortcomings, clinicians became isolated from one another, reluctant to share their professional concerns with colleagues, dreading hearing from new patients about their experiences during the storm, and at the same time concerned that they were putting too much emphasis on the storm's aftermath. "Are we begging off our responsibilities as clinicians when we put so much in the Katrina 'bucket'?" one asked in 2008. Recognizing, as another put it, that "Katrina took a magnifying glass to the tiniest little issue in a relationship or in someone's life and those issues were blown apart by the storm" did not quell the uneasy feeling that "it's been three years already; we should have gotten over this by now, we should be getting on with our lives."

WHEN THE FAMILIAR BOUNDARIES SEEM INSIGNIFICANT

Linda M. Floyd, Ph.D.

In June of 2006, I was invited to speak at an international group of maybe 400 to 450 engineers and safety planners. My panel included a nationally respected architect, an engineer who is now Dean of a College of Engineering, and a law professor versed in issues relevant to environmental law. This was a sophisticated panel of experts and an audience that was unfamiliar and challenging to me. I stood in front of this group and invited them to hear a few of the "Katrina stories" that I had accumulated—a painful letter from my dentist who had lost his home and practice, a

poem sent by a friend, and an account of the experiences of a colleague—to illustrate the human, psychological toll of the storm as we knew it at the time. By most standards, it was a successful presentation. The next day I was invited to join the convention attendees on a riverboat ride. I went to some trouble to accept this invitation. Not until I got on the boat did I realize that my interest was not merely to see the point of the levee breach at the Industrial Canal; my real motive was to have an opportunity to tell MY Katrina story. At that time, "MY" story was relatively straightforward: when I got out of town, where I went,

my material losses, my son's struggles, and my new office. I was aware that hearing the experiences of my patients was already wearing on me, but I did not recognize the profound intersect between my story and those of my patients.

Over the past 35 years I have often felt very lucky to have chosen psychology as a profession. It just suits me. The work plays to my curiosity about people. It is intellectually challenging and intricate. There has always been great emotional reward in the activities. For the past many years, most of my professional attention has been devoted to the engagement that is psychotherapy; an invitation to participate in the hurts, struggles, triumphs, pain, paralyzing conflicts, and sometimes horrific victimization of our patients—events that have potent implications for the health and well-being of an individual, couple, or family. Some of these experiences resonate for me, or touch me in some special way, or maybe even genuinely horrify me. The agreement with my patients has always been that our efforts together are in the service of their health and welfare. As such, it has been my responsibility to attend to my emotional and personal needs outside of the consultation room. Most of us have developed coping mechanisms to keep ourselves renewed and emotionally available as we do this work. We maintain a strong support system. We use ongoing education to keep us informed and confident, and we carefully arrange for respite from our professional responsibilities

In the year following the storm, it became vividly clear that my familiar coping options were significantly altered. There was little or no relief from the reminders of the storm: destroyed homes and businesses, trash piled tens of feet high, flooded cars, no traffic signals. So my respite was compromised and more basic. I became a homebody. I took pleasure and relief in cooking large pots of comfort food to share with neighbors, family, and friends. We made great, politically inspired costumes for the first Mardi Gras after the storm. I cried when a friend sent me a sack of fat earthworms for my devastated garden!

In August of 2006, the American Psychological Association held its annual meeting in New Orleans. A casual review of the program revealed that a disproportionate number of the presentations focused on intervention strategies for dealing with trauma. While this timely focus reflected the sincere concern of our profession, the fact that there were so many different studies and ideas about how to intervene was overwhelming. If only someone could have confidently demonstrated that there were really only a few useful approaches to dealing with this trauma. I didn't care if the ideas were empirically based or clinically based. I just wanted the confidence that goes

with being informed. I wondered if I was working hard enough to find some guidelines for my work with patients. Was I missing something? There's CBT, CID, hypnosis, EMDR, ACT, etc., etc. I knew a little about each of these, and utilized some of the techniques when they seemed applicable, but I did so without my usual confidence and certainly without any semblance of swagger.

I also worried that some of the things I was doing during a therapy hour did not resemble the therapy I was accustomed to doing. In many obvious ways the usual therapeutic stance was abandoned and familiar boundaries seemed insignificant. It was not uncommon to share information about community resources or activities. I was more forthright in expressing my opinion about

what and how things were being done in the city. My feelings were thinly veiled, as I was effusive with my encouragement and unable to disguise my tears and sadness on occasion. More than once, I was at a complete loss for words and the subsequent silences were not intended. I was beginning to recognize, in a visceral way, the intersection between the “stories” I was hearing and the story I was living.

At this point my professional reading group became crucial. This group of six peers began meeting in 2000. We have been dedicated to inquisitive reading on a range of topics relevant to psychotherapy. This intimate group became a safe place where I could talk about my confusion in our work; where I could question myself; where I could use my imagination and stretch myself in terms of responding to the unfamiliar demands in psychotherapy. We were not merely mutually supportive, but rather mutually cognizant of the demands in this uncharted endeavor. We trudged along, we kept trying to understand.

Late in 2008 we began to read David Wallin's book *Attachment in Psychotherapy*. In his description of the processes inherent in intensive, reconstructive psychotherapy and in our subsequent discussions, the meaning of presence in the consultation room began to resonate. This was the point of intersection I had been trying to realize. After hearing approximately 5,000 hours of Katrina stories, I finally understood that being present had nothing to do with the similarities or differences in the facts of my experiences as compared with the facts of the stories of my patients; it had everything to do with the emotional resonance. This was different from compassion or empathy. Therapists and counselors who “have been there” often treat substance abusers or survivors of domestic violence or rape. There is, however, rare precedence for therapists who are struggling to integrate their own trauma while treating large numbers of people needing to do the same thing. As a psychotherapist, one choice is to

lapse into a sort of dismissal of your patients, letting the stories run together, looking for superficial commonalities and easy categorizations. Another choice is to allow for the intersection of stories, and in so doing remain present hour after hour.

If I were to be asked today about the impact of the storm on my work, I would say that I have at once been humbled and enriched by this experience. I think that I appreciate the complexities, the texture of life's experiences differently than I have before now. Having shared the intimate experience of trauma with so many people makes room for a kind of connection I had only sampled and not quite captured before Katrina.

Chris Rose (2010) wrote in a recent article in *Gambit*, "And nothing didn't change." As a psychotherapist, mother, wife, friend and neighbor, I agree.

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FINDING A SAFE HARBOR AFTER THE STORM

Elsa Pool, LCSW, Ph.D.

While I was being interviewed for a documentary about shared trauma I was asked by the filmmaker how it felt to be the rock for my patients post-Katrina. I tried to explain that I wasn't at all

sure that was an accurate description of what happened. My patients were unquestionably helpful to me. We worked together in many ways in an effort to move through the trauma. Being available to my patients, talking, e-mailing with them, was, for lack of a better term, very grounding for me. I experienced my time with my patients immediately post-Katrina as an indication that the recovery of tradition, my tradition as a therapist, was possible even in a time of such internal and external chaos. It was my personal balm, my salve to what in many ways felt like a horrid wound. I was able to sit with my patients in one way or another and hear how each of them was moving through this experience.

The diaspora that occurred in the days or hours before the Storm was incredible; friends, family, colleagues scattered to Texas, Florida, Alabama, and all points west, east, and north. Evacuating for hurricane threats was not particularly new to many New Orleanians, but this time the numbers were large, and for my family it was only the second time for us to make the trek away from our home. Once I became aware of Katrina's landfall, I moved into my own particular mode of dealing with the unknown. I stayed at my computer, made efforts to contact my insurance companies, my bank, FEMA, and most of all other people, my friends, my family. Due to some exceptionally fortunate circumstances I was able to contact some of my patients either by e-mail or in some cases by cell phone. Those calls took repeated effort, sometimes calling five times now and five times in two hours, and with luck a call would finally go through. Contacting patients did not require an internal dialogue, at least not at the time. It was a way to take charge, to do what I had been doing for 33 years, listen to people who came to me so that I could be of help, to provide some relief, some comfort. And, as I look back at my decision, I needed to know how these people who had inhabited my life for months or years were doing, I needed to hear them.

As I think back, I was essentially functioning in an automatic way; this was my survivor mode, and I couldn't quite make sense of any other way to endure. My mind could not settle, I was numb and not numb, what would happen next, how could I, should I, think about where to go, what to do, what was life going to look like from now on? These were questions and feelings that I would eventually be hearing from my patients. This shared disaster brought a new dimension to our work. This was no longer about taking in or sheltering myself from my patients' experiences; this was about knowing, firsthand, what my patients were speaking of.

Like several of my patients, I had temporarily relocated to Baton Rouge. With some investigating I was able to make contact with these individuals. Some of them had been in analysis with me pre-storm, and we agreed that we wanted to return to our work, different as it would be. We met in my son's apartment and in coffee shops; that didn't work. We were not in the privacy of my consulting room, the room that, in times of nontransferential distress, functions as a protective shield, a place of safety, where only my patient and I can gain entry and where the words and feelings expressed within those walls will be heard by only by the two of us. Ultimately I rented an office and we had space to resume our work.

The storm that occurred in New Orleans was not contained; storms raged on in my consultation room. My patients were raw and the pain, the agony, the fury

were unleashed in the treatment. I found myself feeling the intensity of the wounds in a way that I don't think I had ever experienced. I needed to contain, but as my patients would exit I would feel so very full that, more than once, I would have to cry, get water, and settle before I could see my next patient. What word should I put to the experience? It was unlike other times before the storm when I would sit with my patients and could be aware of the process that was occurring between the two of us. Was it the pounding of the words, the expressions of despair, or was it my own loss and uncertainty, the

disquiet within me that was constructing this new and unfamiliar process that ultimately would change the texture of my work forever?

As I sat and listened to the despair, the losses suffered, the anguish experienced, I became more and more aware of my needs to share with friends, colleagues, family. Our then Center President set up a system via the Internet enabling our members to contact one another. Eventually we were able to meet in person at the Center Christmas Party. This communication became a lifeline, a link to the familiar, the ability to share our stories and to find humor in our struggles. I felt as if I had returned home from a journey that I had not planned to take.

This path that we, as clinicians, were traveling was uncharted, at least for us. Phone sessions became common; seeing patients on Saturdays and Sundays became necessary. I drove from Baton Rouge to New Orleans and then back again. Working with analytic patients seven days a week for months seemed barely enough for some who were in the midst of the chaos of recovery. The drive back and forth was one that I never found comforting. But after the Storm, the roads were excessively traveled; 18-wheelers in front of me, behind me, and on the side of me, I was no longer free to choose my speed, my lane, what sometimes felt like my destiny. I found great solace in my work. That had not changed. What had changed was the lack of comfort I felt as I drove from home to work, work to home. My neighborhood was devastated. Not as badly as other parts of New Orleans, but in my world, where neighborhood kids used to be outside playing, where cars would come and go, there was silence, the silence of neighbors who had left, homes unable to be inhabited, electrical wires dripping across the streets. Trees had been cleared so that I could drive to my home, but for many months there was no hot water, no phone service, and, of course, no refrigerators.

And so it went. Slowly my patients returned. By the year's end I was living full time at my home, upstairs in a space that met my needs. Patients asked the

questions that frequently they dare not ask: What happened to your house? Any damage? Insurance? Everyone okay? We knew that we had shared something, something that linked us together in a way that had not existed before. It was inevitable. It could not be denied. Ultimately we would return to our way of working, but it would be changed. We survived together. We shared an experience, we lived through a disaster that would soak down to the cellular level of our lives, and we did it with one another. We now knew each other in a way that we might have never known each other if such an event had not occurred. As I reflect on these years since the Storm, I am aware of being different, personally and professionally. I am not uncomfortable in this new situation; I believe that it was through sharing this experience that my patients and I grew and came to understand the human factor that we all share.

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A KATRINA STORY

Deborah R. Poitevant, LCSW – BACS

We therapists think we know, but we deny just like everyone else. At least that was my experience. It wasn't until deep into 2006, when I was taking a break in the staff room at Trinity Counseling

and Training Center, that I just spontaneously started crying. Really crying. Couldn't turn it off crying. A trusted colleague walked over and stated, “That is what PTSD looks like.” He was right, of course. I had known it was lurking, and yet I refused to acknowledge its presence to the degree that it needed to be observed and respected. My grandiosity had gotten in the way. I had become the client.

And so began my own slow, uneven journey toward—what would the word be? Recovery? I don't think we really “recover.” Healing? Too disease based. I have settled on “reconstitution.” In my own interior world, I see the little blocks of “me” that constituted Debby-before-the-storm, tossed into the air and thud back to the ground. Some aspects of Debby stayed cohesive and some didn't. Today, many blocks of “me” have moved around and been “relocated” through the process of my own personal work blended with the lived experience of being part of this community.

Homecoming

I remember the excitement and the fear as we crossed the Causeway back into New Orleans. It was October 2, 2005. We knew it was safe to return home; our electricity was on because the answer machine had worked the day before. We had heard so many stories, my family and I, about the city and its lawlessness—watched it on TV. I was anxious about our safety.

Coming down the avenue was a ramble, debris and brush everywhere. No lights at all. We drove and looked and looked some more. Audubon Park had soldiers camped out in it. That was good. But we lived in the Garden District—several miles away. What or who would be there to keep us safe? No sounds. No birds or animals anywhere. We turned the corner to our street and one person was in the middle, raking. My dear neighbor, Linda. It was like a movie! I jumped out of the car and ran to her—we hugged and screamed. At last someone who was like me. Someone who understood. And then I heard the helicopters.

Heroes!

We were going to save the world, we therapists—at least we would save our world—the New Orleans world. We were going to get involved and help organize mental health services for the returnees, refugees, evacuees. I knew I had an agency to run, so I had a cause. But no one was there. All my staff was gone, the students dispersed to other schools and states. There weren't even any clients to benefit from our heroic intentions. We organized ourselves and, as staff came back, we went through files and closed cases. We tried to generate a sense of order, “normalcy.” We refocused and defined a short-term goal. What was it? Why, to treat PTSD, of course! That's what everyone was talking about. We planned an intensive training; we were expecting folks to be knocking down the door for services. We trained tons of therapists, but where were the clients? We were so naïve. We began to get calls from practitioners from far away who offered to come down for a week or two to provide services. We had no resources to organize such an effort and provide something for these good-hearted folks to do in the early days. So many services; so underutilized; so stressful. We did not understand that few people were ready to deal with this trauma in any formal way.

We Are All in the Same Boat

The students, who provided many of the services at Trinity Counseling and Training Center, started to return in the spring of 2006. While thinly staffed, over time we set up a very busy post K counseling center, offering all sorts of groups for kids and adults. We started seeing first responders who never seemed to stay very long. A revolving door of the worn out and burned out. And we saw therapists encountering vicarious traumatization.

A sort of “knowing” became apparent as the days and weeks wore on. If you were here before Katrina and returned to clean up the mess or deal with whatever your “stuff” was, you knew. Whether you lost your house or had no physical damage at all, you understood that we were all in the same boat. Clients “got” that right away. Twinship transferences were everywhere. Rapport grew quickly in the relationships and work was getting done. But for whom?

I always think in terms of a split-screen TV in my head to track transferences—mine and the client's. Now the TV was fast-forwarding, and it was challenging to stay clear about who had what issue. We clinicians had to work hard to stay focused and grounded. Additionally, I came to understand what a gift it was to be present to the empathy my clients exhibited for the universal pain being experienced in New Orleans. So much compassion in the midst of so much pain and grief.

The Outsiders

One could always tell an outsider—and there were all types. Many wonderful people like all of the volunteers coming to help gut homes, serve hot meals, and put lives back together. They were sensitive and affirming of the enormity of it all. But there were also lots of insensitive and downright offensive individuals. A colleague referred to this category as “carpetbagger.”

Dealing with the insurance company and disinterested adjustors was the most personally traumatizing for me. FEMA and the Road Home ran a close second. Would I get money to fix my house? I heard literally scores of the same frustrations from friends, clients, and staff. Many times I wanted to throw in the towel. My children encouraged me to keep fighting. I needed some cheering on. My own internal compass was fragile. I was stretched very thin but fighting for what I believed in gave me the reason I needed to keep putting one foot in front of the other. I was really, really tired of these adjusters. I hated what they were doing to people who had fewer resources than I. Anger was a big motivator for me back then.

The Daily Grind

I remember dreading having to go to the bank. Some people hated the post office, but I kind of liked it. Everyone talked and shared their stories. It was comforting in an odd sort of way. But the bank was incredibly time consuming and frustrating for me. A certain family member's checking account, for which I was a guardian, had all the checks and documentation missing due to the Katrina flooding. It took forever to get copies for the courts in Washington, DC, which needed an accounting. Trying to explain the situation to the clerk of court in DC invited a retort that Katrina was “no excuse.” I was shocked at the perception and behavior of that individual. And I was sad that people far away had forgotten or didn't care in the first place.

You learned that if the plumber, electrician, contractor, or adjuster called, you answered. And if he was at your house, you dropped whatever you were doing to go meet him. Clients brought cell phones to sessions. It was understood that if any of the above persons phoned, you took the call. And you left to meet him. Not doing so generated huge anxiety on top of the stress already there.

A Grief Observed

With all due respect to C. S. Lewis, I take his premise and apply it to my own experience of the trauma we call Katrina or “the storm.” For all of us, I believe, it is in the observation of the event (our own or another's)—the witnessing, if you will—that allows that event to settle into a place inside our lives rather than remain separate from it. Heinz Kohut said that being understood is for an adult as being held is for a baby.

I believe it's more than the observed event itself. It is also the cascade of other hopes, wishes, and dreams associated with that event, and their inevitable loss or shift, that contributes to the deeply felt trauma. It protracts the pain, and grieving seems endless. I believe that we don't “get over” these things. Instead, with support and encouragement, in time we relocate them in the interior of our hearts and minds. This is what I see as the reconstruction/reconstitution of the self. This dynamic contributes to our wisdom and adds meaning to our lives. Our capacity for compassion grows and our empathy for ourselves informs our ability to be with, and witness, others' histories. As a therapist, I am less timid to call out “trauma” now. I feel I am more highly attuned to the client's loss and respond from experience. I find I educate more so folks can

feel “normal” and “less crazy.” I am also more directive—probably because I realize how precious life is and all we have is “now.”

And with all due respect to the human condition that would like to “move on,” maybe we are better off “moving with.”

At the time of the hurricane, Deborah R. Poitevant, LCSW – BACS, was Director of a not-for-profit mental health clinic in New Orleans.

AFTER KATRINA: ALONE IN A FLOOD OF CIRCUMSTANCES

Kathryn L. Nathan, Ph.D.

In T. S. Eliot's 1950 play, *The Cocktail Party*, one character has found herself suddenly alone facing an abyss. She says, “I would not have chosen this way, had there been any other. It is at once the hardest thing, and the only thing possible.”

That's what it was like for me as a therapist in New Orleans after Katrina. It was the hardest thing and the only thing possible, a journey into the unknown. I left New Orleans the day before Katrina hit. My sister had insisted that I leave, and the fire marshals showed up in the lobby with guns. I was a single woman slowly building a life in the town I had left for many years. I was lucky to have family around me; a sister who literally saved my life; a father who bought a house for us in Zachary, a small town outside New Orleans, when our own homes were lost in the flooding; and patients who reached out to me, sending texts and e-mails, finding ways to stay connected.

One of those patients is Annie. Annie and I had officially stopped therapy in 2008 when it was clear that phone sessions were not enough. Before Katrina I had helped this proud, smart, tenacious woman apply for and get disability, much to her shame and relief. We had worked closely on her trauma history, growing up painfully with a psychotic mother and emotionally distant father, living in poverty, going on to attend a prestigious school outside of L.A. Back in New Orleans after a breakdown, she was agoraphobic and paranoid, sometimes retreating to her bathroom for days on end so as to avoid any human contact. At times she went into panic states and could not come out. Her links to life were her dog, Rosy, and me.

While caught in the endless traffic jam that was the evacuation, I reached out to Annie. I didn't think about it at the time. I wasn't aware of my identification with her, a single woman staying alive largely because of her dog, disenfranchised from her family, alone in the world, traumatized by men and by life. I'm a motherless daughter and so is she, although her mother is alive and mine is not. And her father is overwhelmed by her just as mine can be by me. We both love animals. We share a love of language. And Annie had so much promise. She is brilliant and it all came crashing down. I can understand that, too. There are many parallels; rescue wishes abounded on both sides. I feared she would not know about the storm as she only left her apartment when it was essential. The mere sight of a newspaper could send Annie into a severe panic. So there I was, stuck on the highway, and I suddenly thought, “OMG, Annie; she won't know; she could die.” So I called her. There was no hesitation.

I first got the answering machine. I started talking knowing she may be listening. “Annie, this is Dr. Nathan. Please pick up the phone. There's a storm coming, category 5 hurricane, everyone has to evacuate. You have to get out!” She picked up. She didn't really know. She had been out but didn't grasp the emergency or the immediacy. She assured me she would find out more and do what she needed to do.

I didn't hear from Annie for several days. It was hard not to know what had happened to her. I knew she would never leave her dog, that she might be dead. Then, maybe five days into the evacuation, I got a message: “If anyone calls, Rosy is a seizure dog.” I had to smile, Annie does not have seizures. This meant that (a) she was alive, and (b) she had Rosy.

I'm not sure when we spoke again, but in time she got to a motel in Arkansas and we began having regular phone sessions. The content was largely FEMA related, being a stranger in a strange land, shady landlords and intimations of very bad things, so much anxiety and helplessness.

That fall of 2005, I would talk to Annie as I walked around this big strange house in Zachary. I was alone there, working a temporary job and driving into Baton Rouge to see patients in some other person's office, not yet back in my own office in New Orleans.

It was getting hard to listen, not just to Annie but to those patients who did not talk about Katrina at all, who quickly became preoccupied with the same issues they had before, the same character armor. Even as I showed up for them, and for life, I could feel myself shutting down. My life had capsized, but to my

patients I was still Dr. Nathan. To be a therapist in the winter of 2005 was at once the hardest thing and the only thing possible, and it was my livelihood.

Annie began telling me about disturbing interactions with her psychotic mother, all the ways her father could not tolerate hearing her distress or her need, how FEMA and the state of Arkansas had failed her. She got a bird and that was good news, but the rest was bad. At some point she began accusing me of not hearing her. “You don't get it, you're not listening, you don't want to

know what really happened.” This was unnerving. Of course I was listening! This was projection, I reasoned, she wasn't hearing ME. Or maybe this was displacement; it was her father who wasn't able to hear her, her mother who denied her reality. Possibly I had saved her life!

But Annie was getting worse, more symptomatic, more isolated and depressed. I insisted she get help in Arkansas, at least call a crisis line if she felt suicidal because I wasn't there. She did, and the next day informed me that the phone counselor said she was having an inappropriate relationship with her unprofessional therapist who was encouraging dependency by staying in touch with her. Oh no. Was I a bad therapist? I didn't know.

I didn't want to be Annie's lifeline; it was uncomfortable and scary. I was trying to help her hold on; she was having horrific nightmares, every possible way to die, but this counselor and several others seemed to think I should cut off all contact with her completely. This was excruciating. I didn't know what colleagues were doing with long-distance patients. I only recently learned that five years after the storm some therapists are still doing phone sessions or Skyping with relocated patients—whatever they can do to keep treatment going. So I wasn't alone in that attempt, but at the time I thought I was.

We did continue phone sessions. One night Annie started really pushing me, insisting I was not listening to her. Finally I said, “Okay, maybe you're right. Maybe I think I'm hearing you but I'm not. Please tell me. I'm listening now.” She then told me how on the day of Katrina water had come rushing into her house, up to the roof. She didn't think she would get out, but she did, wading through that horrid street soup with her dog, trying to escape. In that time she saw dead bodies, dogs being electrocuted, dogs strapped to poles unable to flee. Annie was crying really hard as she spoke, and I thought my heart would burst it was so horrible and sad. And then Annie started screaming, a long, loud, blood-curdling scream that seemed to go on forever. It was the most terrifying sound I have ever heard. Maybe she said this or maybe I dreamed it,

but my recollection is that when she finally stopped screaming, she said, “That's what it was like.”

In time I did go back to New Orleans. I resumed my practice and started working at an agency. Unable to return home, Annie got a therapist in Arkansas and we drifted apart. I felt bad about that, but I had stayed with it as long as I could. I had come to think I was in the way, and I couldn't do it any more emotionally. I had been held up at gunpoint on my front porch, moved to two different apartments in the city, lost half of my practice.

On the five-year anniversary of Katrina, there was voice mail from Annie. “Hi, Dr. Nathan, I was thinking about you today, with all the media coverage of Katrina, it must have been hard for you, I hope you are okay.”

I called her back. She sounded so much better. No more therapy, but the dog was good, the bird had learned meaningful speech, and Annie had e-mail. I told her that I had been thinking of her with our conference coming up and asked if she had anything to say about therapy after Katrina. She wrote back: “My therapist called me on the day Katrina came to New Orleans. She was going out of town, having been evicted because her apartment was vulnerable. She knew that since I was isolated, had no TV or cable service and my only family was in Europe, I might be in trouble. She was right, but there was nothing she could do. So I told her all was fine... . I did the same thing with my father—in France... . Eventually, I wound up in Little Rock and Dr. Nathan was in Louisiana. At that point, I had talked to so many people who barely survived the storm, and were so upset that they could hardly go a day without reliving the thing out loud. My suffering seemed, not worthless, but so much less. I called Dr. Nathan and spoke with her; it was supposed to be a session. I understood that I had censored my experience while I was escaping from the storm.

I don't want to go in to what I had to do to get to what was left of the highway. But I needed her to acknowledge it. I finally called her back and made her listen to a real account of what happened. She was quick to say what was happening; that she hadn't wanted to hear I'd been traumatized. It made me feel much better. That may seem to be a small thing. But, at the time, almost all my time was occupied by dealing with FEMA. It mattered. A lot.”

I thanked Annie for writing, then heard nothing from her for several days. Finally, she replied that being in touch with me had set off a panic, but “only for four days, which is kind of a record for me. But the nightmares were pretty explicit: I was reliving the guilt I felt during the flood time. I rejected the offer to

go to the—I don't know, high school gymnasium—because, of course, I couldn't take Rosy. The water was only about a yard deep in the kitchen, but it seemed to lap higher all the time. I knew there was a crawlspace above, but I didn't have anything to break into it, much less to haul a 70-lb. dog on to the roof. So I spent that night listening to Mayor Ray Nagin anticipating a flood and reconciling myself to the fact that I might die. I realize this seems artificial and … I don't know the words. But what I came up with in that night was a realization that I couldn't live if Rosy died like this. So I came up with a plan: If we were going to drown, I would kill her as quickly as I could and then swallow water quickly as I could."

Annie's panic makes sense to me. Maybe there are no words for what she went through during the storm. But I know now what I did not hear, even when she spoke or screamed. She was describing a nightmare that she lived. It's hard to listen to that kind of pain, harder still when you have your own, hardest of all when you are helpless in the face of it. So, no, I didn't want to listen. I did not want to go on that journey into the abyss alone, with her or at all. Who would?

Really listening is hard. With Annie, it was the hardest thing, and the only thing possible.

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