I Don't Want This Knowledge: Understanding the Effects of Hurricane Katrina on Therapists and Therapy in New Orleans[1]

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I would like to start by thanking Kathy Nathan for her vision in realizing that the mental health community in New Orleans needed an opportunity to talk and think together about the aftereffects of Katrina, for her dedication in making it happen, and to say how honored I am to be a part of her plan. Thanks also to Shirlee Taylor and the Far Fund for making all this possible. Most of all, I want to thank each of you who spoke with me in person when I came to New Orleans in September (just after Gustav had given everyone another cause for alarm) and to those of you who spoke to me by phone more recently. I was very moved by the openness and the trust each of you showed me and the stories you all had to tell. I learned a lot from your experiences, as I hope you will be able to tell.

Those experiences were very wide-ranging. As a former epidemiologist, I don't want to pretend you represented a scientific sample. But just to give you a sense of the varying experiences of the people I spoke with: There was a distinguished psychoanalyst who has given up his analytic practice to work where he feels the need is greatest—in a public clinic, medicating the most vulnerable survivors of the storm. "This new job will take up there rest of my life," he told me. There was a professor of psychology and trauma expert, who, within a couple of days of the storm, organized a program on the cruise ships to support the first responders, who had themselves often suffered the heaviest losses during the storm. Along with the team she had assembled, she brought what she calls psychological first aid to the first responders and their families. There were the administrators and staff of a not-for-profit clinic, seasoned school counselors, young professionals starting out, experienced professionals continuing with the private patients they had had in practice before the storm. And there were some who had decided to leave New Orleans after Katrina and who continue to struggle with their sense of loss every single day.

Every one of you spoke directly, and indirectly, of the sense of precariousness that has been with you since August 2005. Admittedly, when we spoke, that vulnerability was heightened by Gustav, but all of you have found your work changed since you were able to start working again after Katrina. As one of you put it, "We have lost something very precious. I'm not sure it will be regained." Most also spoke of being very worried about how much need there is for your particular skills right now. In fact, that need is growing, and all of you share a concern that you cannot personally do more.

You represented a broad range of psychological approaches as well: family systems, neuropsychology, psychodynamic therapy and psychoanalysis, psychiatry, cognitive behavioral, existential, dialectical behavioral therapy and EMDR. Despite these different orientations, there were consistent themes that folks returned to time and again, and I want to think through some of those themes with you.

When I was here in September I asked about your personal experiences both during and after Katrina and about your professional life when you were able to go back

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[1] This talk was given at the invitation of the Far Fund Project, Birmingham-New Orleans Psychoanalytic Center, February 5, 2009.

to work. Some of you got back to work almost immediately after the storm, opening makeshift offices in Baton Rouge, to be there for patients who were themselves working on the front lines of the recovery effort. Or, for the first time, some of you resorted to regular telephone sessions (well, as regular as you could manage given that everyone was in a state of such uncertainty about when they would be able to return to the city and what they could expect to find when they got there). For others, the personal losses or psychological toll the storm took meant it was longer before you were able to get back to seeing patients. But to a person, in your own way, you each told me what you felt you had lost in the aftermath of Katrina. And it goes without saying, when I am addressing an audience of mental health professionals, that those losses were not confined to physical loss. As one of you said to me, "We all felt we lost—and in some respects still have lost—the life we had."

This where my title, "I Don't Want This Knowledge," comes from. I think the knowledge that each of you learned personally from your Katrina experience—and that you see with your patients every day, whether they were in treatment during or immediately after the storm or whether they have recently begun treatment—is knowledge that none of us wants to have.

I'm going to digress a little here to tell you about a patient of mine, a survivor of a very different kind of disaster. I'm using this example because the words, "I don't want this knowledge" came out of my work with Noam. The thought they express is frequently the legacy of having survived a terrifying, life-altering, and often life-threatening experience.

Noam was a 22-year-old college graduate driving with his father on a wet road one fall when the car went into a skid, plunged down a steep embankment, smashed into a tree and turned over. Despite the fact that they were both wearing seatbelts, Noam's father was horribly mangled and killed. Noam was trapped, hanging upside down beside his dad's disfigured body for what seemed to him to be many hours for, in these situations, time stops. But it was certainly far too long before he was cut out of the wreckage by firemen.

Before beginning treatment—several years after the accident and for an apparently unrelated cause—Noam had been living a marginal life. This very bright young man was barely employed. Unable to plan a future, he was withdrawn from friends and family and skating gingerly on the thin ice of a life constructed to avoid anything that would trigger memories of the freak accident.

Several years into our work together, on September 12, 2001, the day after the terrorist attacks in New York, Noam called to say that he would be happy to give up his session so that I could volunteer at Ground Zero. I thanked him but told him I would see him at the regular time. When he came to his session, he repeated the offer. Here was another instance of random violence taking not one but thousands of lives, and he didn't want to think about it with me. When I didn't comment, he was silent. Eventually I asked him what was on his mind. He burst out, "The ability to take people's lives impresses me. It's an erotic rush, like a bloodlust." But he quickly became deflated. "I can't get there," he told me. "At least, I can't stay with it. I know what happens after all the killing ends. I don't want this knowledge. It's unbearable. I don't want to accept that it just happened, that there's nothing you can do to stop it or to protect yourself. It makes me feel like a girl. I don't want this knowledge."

There are several parts to this unwanted knowledge that is thrust upon people who survive such frightening experiences. There is the fact that such experiences can strike at random. Afterwards there is an ongoing knowledge of vulnerability. For this formerly tough kid, a high-school football player, being so vulnerable made him feel like a girl. Privately, he even wondered whether he was gay because he’d lost a certain machismo. Then there is the knowledge that this sense of precariousness remains, you are changed, possibly changed forever by the knowledge of that vulnerability. And then there is the knowledge that the rest of the world doesn’t know what you know and would not welcome being told. Lynette Coffey, a clinical psychologist from here was quoted in the *New York Times* in August 2008, saying, “Our 15 minutes of fame are gone. It’s over, so you stop talking about it.” In other words, we’re not supposed to be talking about this any more, no matter how badly we feel. We’ve worn out our welcome as survivors.

Many of our fellow professionals also don’t want this knowledge. Psychoanalysts have traditionally conflated the consequences of adult onset trauma—of massive psychic trauma that strikes in adulthood—with childhood trauma. It has been a psychoanalytic conceit that those who continue to suffer the consequences of a massive trauma after the trauma has ended are really exhibiting the symptoms of earlier unresolved conflicts. But psychoanalysts are not alone in this belief; it is rife throughout the mental health profession as a whole. On December 5, 2008 (just two months ago), I came across the following comment in the *Times* that made me leap out of my chair and throw the paper to the floor in disgust. The former director of mental health in one Louisiana town, where a lot of refugees from the storm fetched up, was quoted as saying: “People who had no serious problems before the storm are likely to recover well.” In other words, if you are still suffering psychological consequences from the storm, there was something wrong with you in the first place. I call this blaming the victim, and also deluding oneself about one’s ability to withstand massive trauma.

In 1986, as a member of the task force that was charged with refining the definition of Post Traumatic Stress Disorder for the revised edition of DSM III (and remember that the diagnosis first appeared in DSM only in 1980), I raised this question of predisposition because I objected to the statement suggesting that predisposing factors always influence the development of PTSD. I had a very big stake in this because my own research with Vietnam veterans ten years earlier had alerted me to the danger of assuming that the reaction to a sustained traumatic event must always be attributed to earlier causes. Consistent with my traditionally psychodynamic graduate training, I was sure that I would find predisposing factors leading to Post Vietnam Syndrome (as we called it then), the psychological disorder I was attempting to measure. When I analyzed my data, I did find a statistically robust syndrome that measured long-term stress reactions (what we would now call PTSD) as distinct from anxiety and depression. I also found an interaction between certain levels of predisposition and exposure to low or moderate levels of combat. That is to say that at low to medium levels of combat those with some predisposing factors did develop symptoms of long-term stress reactions. But, in the end, my hypothesis was wrong: At the highest levels of combat, at the greatest exposure to terror, predisposition played no role in determining who would later develop stress symptoms. These findings have been replicated several times. It was this finding

that set me on a course to understand what happens to people when they are exposed to terror, and why the reaction can last so long.

The fact is that many mental health professionals don't want to believe that the reaction to a massive psychic trauma can sometimes occur independently of predisposing factors. And further, they don't want to be reminded of the lingering effects of a disaster because it makes all of us feel vulnerable.

Here's an example (one of many) to demonstrate how reluctant the general public, the media, and politicians are to accept the possibility that survivors experience painful and lasting symptoms. After the Oklahoma city bombing in the early nineties, city officials—with the help of the media, church leaders, politicians and the press—started to tell stories that emphasized religious and political messages, as in: "We have been made stronger by this experience" and "With the help of God we have joined together and overcome our difficulties." These socially meaningful but often personally empty narratives were the ones survivors were expected to tell themselves. The personal narratives that dealt with the ongoing pain, disorientation, and fear that survivors were experiencing were called "toxic" and their telling was discouraged.

You see what we, as mental health professionals, are up against. I'm sure each of you can give me examples from your own press and politicians about how well New Orleans and New Orleaneans are doing right now. And some patients, too, are impatient. "When is this going to be over?" they ask. "Why haven't I gotten over it yet?" Or, worse, "Why haven't you gotten me over it?"

Of course, there is progress in New Orleans. Houses have been built or rebuilt, businesses are opening, the schools are doing better, new alliances are being forged. But that's not the whole story, and we therapists have to make room for people who need to tell different stories (toxic stories, if the politicians from Oklahama City are to be believed) even as their external lives appear to have regained a sense of normalcy.

Which brings us to the question of latency—the fact that sometimes posttraumatic symptoms don't emerge for many months, sometimes even years, after a stressful event. It's a bit like how many of us—not only those in and from New Orleans, but the rest of us watching anxiously from the sidelines—thought that you had dodged the bullet on the evening of August 29, 2005, believing the hurricane had passed without too much damage. Then the levees broke. Latency is, as one of you said to me, trauma's slow burn. It's like driving down one of those New Orleans streets that look surprisingly untouched and then you see the water line midway up the house. Something happened here, but we are too busy taking care of business to pay attention to our own emotional needs right now.

As the sense of exterior normalcy has increased, some people are becoming aware that they themselves still feel undone by the storm. Others don't recognize that a disabling depression or unraveling marriage or constant fighting with the kids stems from feelings that got stirred up during the storm and its immediate aftermath.

Many of you told me that you have more referrals now of people who are talking about the storm than when it originally occurred, and that more of these referrals are men. In one case after another, as treatment unfolds, what may not always have been immediately apparent slowly becomes revealed: The disruption of everything that was familiar—not just in the outside world but also in one's sense of self—underlies the feelings of frailty and desperation that have brought the patient to treatment. Now, more

than three years after the hurricane, the director of one community mental health center told me that, for the first time ever, she recently had to institute a clinic policy limiting the number of suicidal patients any therapist can see.

Many of you have understood this period of latency between Katrina's occurrence and the time that people are paying attention to their psychological symptoms as an example of Maslow's hierarchy of needs. At first, people had to worry about putting a roof over their heads and food on the table, deciding whether to stay or whether to go, finding a school for the kids. As things settled down, the nagging sense of being somehow changed took on more urgency. As people continue to suffer the consequences of the hurricane—particularly in the face of positive stories about the re-building of New Orleans, the re-vitalization of New Orleans, etc.—they begin to wonder why they aren't rebuilding themselves so well, why they haven't yet recovered, and they start to withdraw from others. This period of latency is common to posttraumatic states, whether the trauma originated in a manmade or natural disaster. Some combat veterans don't manifest symptoms until many years after they have returned home, often the symptoms occurring in response to the outbreak of a new war. There are many instances of World War II veterans presenting with symptoms twenty-five years after the end of the war, and the same is true for Vietnam veterans, particularly as the U.S. continues its wars in Iraq and Afghanistan. Or, another example, survivors of the Nazi Holocaust who showed this same kind of "frontier energy," as one of you described it, establishing themselves in a new country, rebuilding families and lives, only to discover that the Holocaust's toll became apparent when everything else appeared to be settling down. So we have to assume that the psychological aftermath of Katrina will continue to assert itself for years to come.

Of course, I am not arguing that all the psychological problems that occur after a disaster of this magnitude must forever be laid at the feet of the storm, nor that there are not resilient people who remain less affected, but I am emphasizing here that many do not simply get over it, even if they have not suffered physical damage. That this is knowledge that we as citizens don't welcome, that as survivors we don't welcome, but as mental health professionals we must be open to.

Every one of the psychotherapists I spoke to about the storm and its aftereffects was very painfully aware that things would never be the same again, that with this knowledge of precariousness their lives and their patients lives and psyches had been changed forever. Some of them felt that they had received this knowledge earlier in their lives from a parent who had survived a different kind of trauma, or from an earlier brush with mortality, but that now this knowledge is something you share with your patients and with one another … and it sets you apart. It is one thing to have an intellectual grasp of the fact that another hurricane will come, that safety is an illusion, but now there is another kind of knowing, a gut knowing that pervades your very being.

And yet, some of you ask, are we making too much of this? Are we begging off our responsibilities as clinicians when we put so much in the Katrina "bucket." Certainly by now you have become aware that it is not merely the effects of the storm that you see in your practices but how it has exacerbated earlier problems. As one of you said, "Katrina took a magnifying glass to the tiniest little issue in a relationship or in

someone's life. Those issues were blown apart by the storm. Now people have to deal with those problems."

One psychoanalyst described how "Everything we had been talking about before the storm came to the fore. Suddenly a longstanding lack of assertiveness became a question of how to stand up to the goddamn contractor, just like the didn't stand up to other people earlier in their lives." And in the transference you are finding that your patients' early histories are asserting themselves as they always do. Ignoring your best efforts, some patients continue to feel totally alone in coping with the aftermath of the storm, their therapists no more than bystanders, like disinterested city, state or federal officials, watching them flounder through the recovery process. Other patients become utterly dependent, wanting their therapists to fix everything, to supply the names of contractors, carpenters, glaziers. Still others feel they have to heal their therapists before they can turn their attention to themselves. So it's business as usual plus Katrina.

Before I go into more depth about how a massive trauma in adulthood can lead to serious and long-lasting changes in the sense of self—can, in some cases, lead to the collapse of the self—I want to make a distinction that most mental health professionals characteristically fail to acknowledge. That is, the difference between the consequences of a trauma as it affects children and as it affects adults. I think this distinction frequently doesn't get made because of our profession's knee-jerk tendency to attribute all traumatic reactions to earlier problems. (Boulanger, 2007)[2]

When children face a trauma, something that overwhelms their feelings and their ability to cope, that event often occurs in the context of an attachment relationship. In childhood, trauma is frequently a betrayal of trust. And when children face massive psychic trauma that is not in the context of an attachment relationship, as we have seen in the bombing of Gaza in the last month, or for those who were marooned in New Orleans with family members, their reactions are mediated by the adults around them, who themselves provide an emotionally protective shield … or not.

When children do face an attachment trauma, when they are threatened with sexual indiscretions or violence, they dissociate to escape unbearable affect, forming split-off self states to encapsulate the traumatic self and object representations, leaving other self states free to engage a less threatening world. However, in her recent book, *The Dissociative Mind,* Howell points out that the capacity to dissociate decreases with age. When faced with massive psychic trauma, an adult *will* dissociate, what I call catastrophic dissociation, but this dissociation does not create further splits in a developed personality. It does provisionally offer protection from terror, but ultimately it leaves the survivor in a state of confusion and anomie.

There is another difference: How children remember traumatic situations frequently differs from the way that adults remember them. The discussion about the difficulties inherent in reconstructing memories of childhood sexual abuse is ongoing. Depending on the age of the child and her relationship to her abuser, memories as such may never have been formulated but are rather stored in dissociated self states. The fact that most sexual abuse happens in private, often with threats about the consequence of disclosing what has happened, allows room for distortion and further contributes to the shame, uncertainty, and self doubt many survivors of childhood sexual abuse—and their

[2] A list of bibliographic resources is given at the end of this paper.

therapists—have to endure. For these patients, the refrain is frequently, "Did this really happen to me?" Which often translates into, "Can I bear, or do I dare, to take this seriously?"

Often the memory of an adult onset trauma is indelible and, unlike other memories, it is unchanged by the passage of time. When a trauma is survived in adulthood, the refrain is more likely to be, "I should have gotten over this by now” or “I'm not in danger any more. What's the matter with me?" or maybe “It wasn’t so bad, was it?” Alternatively the refrain is, "I shall never get over this. I am marked for life." When shame is present, and it frequently is, it is not so much about what one has survived but that one has not survived psychologically.

In adulthood, abused children can function relatively stress free in situations that do not call to mind the original abuse; those who have been traumatized in adulthood do not always have that freedom. In childhood, trauma becomes part of self experience. In adulthood, it can cause the collapse of the self. Subjectively speaking, in adult onset trauma the sense of a collapsed self first experienced during the catastrophe can permeate every aspect of the adult trauma survivor's conscious and unconscious life.

I’m going to explain what I mean by that in a lot more detail, but first I should say that at some point in the course of the conversations I had with you, almost everyone mentioned feeling that after the storm there was always someone worse off. Whether you had actually lost a house to the flooding or your house had been untouched, whether family members had been in grave danger or you had remained together in safety out of the city, all of you acknowledged that others had had it worse.

That may indeed be true, but this does not mean that you have not suffered sometimes very painfully in the storm’s psychological aftermath. It is difficult to have survived unscathed materially and nonetheless feel that you have been deeply affected by the storm. That is the guilt that many of you carry around. So before I explain to you what I have in mind when I speak about catastrophic dissociation, I am going to describe the situation to which many of you who were not caught up in the storm itself may resonate. Chuck Strozier is a historian and self psychologist who studies the survivors of massive psychic trauma. His observations in New York City immediately after the terrorist attacks are helpful in understanding the reactions of many of you who were not physically present or immediately affected by the storm. After the attacks, Strozier (2002) described “zones of sadness” in decreasing order of magnitude radiating out from Ground Zero, reflecting what he called the apocalyptic power of the destruction of the World Trade Center. Those people, so often the most disadvantaged, with the fewest resources to leave, who remained behind in New Orleans—and found themselves desperately trying to escape the rising waters or trapped in a chaotic and dangerous city, faced with indifference and anarchy, separated from family members, and the first responders who themselves faced life-threatening situations and a terrified population—were in the equivalent of Strozier’s first zone. But for those of you who left the city—who thought the city had survived the hurricane, then watched helplessly as the city flooded and burned, desperately searching Google Earth to see if you could get a fix on the condition of your homes, uncertain whether you would ever be able to return to New Orleans or to your home, if indeed you had a home to return to—for you, the psychological effect was often closer to what Strozier calls apocalyptic anxiety. You were inundated not by floods but by news coverage, unimaginable images of people

begging to be rescued, dead bodies floating in the streets or abandoned by the receding waters. Here was a comprehensive vision of collective death, of vast suffering, of the end of the world, of the end of your world, of New Orleans and your lives as you knew them. Such horror alters the very ground of our being. It changes our relationship to death and to our sense of ourselves. Also—and I will come back to this later—Strozier points out it is not easily symbolically internalized; it is indigestible emotionally and cognitively. For those who were in the first zone of terror, catastrophic dissociation, which I will describe in more detail in a moment, is triggered by the immediate and very real terror of anihilation. Many of the rest of you know intimately the disabling power of apocalyptic anxiety that Strozier describes.

Apocalyptic anxiety and catastrophic dissociation do overlap. The latter can lead to a collapse of the self, leaving the survivor feeling as if nothing about herself or himself is familiar, as if her experience of the world and of herself has been unaccountably and horribly altered, and there is no way back to the familiar, to the way things were. In talking about the city after the storm, one woman said to me, "All the landmarks are gone. My husband, who grew up here, couldn't find his way around." There's a parallel here to the loss of the familiar self after an experience of this magnitude.

When I started to write about adult onset trauma, I found Daniel Stern's book, *The Interpersonal World of the Infant,* and the way in which he describes how the core self is achieved by the preverbal integration of the senses of agency, physical cohesion, continuity, and affectivity to be a very useful starting point. This autonomic psychic platform is facilitated by the intersubjective self and later by the verbal self, with its capacity to make and to derive meaning (both the verbal and intersubjective selves will turn out to play a significant roles in the lives of survivors in New Orleans). At its worst, during and after catastrophic dissociation, each facet of the core self becomes chronically dysregulated. But even when it is not at its worst, in being confronted with a terrifying situation, all of us find some of these senses of the self, these ego strengths, if you will, start to unravel.

Neuropsychologists and biologists have accumulated an impressive body of evidence of the chronic dysregulation of neurological functioning that occurs after massive trauma. Although there is an exciting consilience between what survivors of massive psychic trauma tell us about their sense of collapse and the recent neurobiological findings (as summarized by Bessel van der Kolk, for example), there have been few attempts to understand the phenomenology of the collapsed self. That is what I would like to try to do here, for the effects of catastrophic dissociation continue to echo through the traumatized core self long after the actual danger has ceased.

The core self is the unarticulated ground against which the figure of experience is projected. Normally completely taken for granted and operating out of awareness, it is the psychic equivalent of a heartbeat or regular breath. In trauma this core self is catastrophically and chronically dysregulated, not just neurologically but psychically as well. At this autonomic level, physiological and psychological experience inform one another. Terror leaves a lasting biological impression with profound psychological reverberations. Many of you will recognize some of these symptoms in yourselves and your patients. For those of you working with patients or knowing people who were exposed to the worst of the storm, the entire syndrome may be uncomfortably familiar.

I start with the sense of agency. Paradoxically, it seems, most of us do not question that we are the author of our actions until we have lost that conviction. Most of us share the conviction that we can and do control our lives. Of course, that conviction is an illusion, but psychoanalysts have been addressing this **necessary** illusion for some time: Donald Winnicott's growing baby bases her sense of security and trust on the illusion that she can magically produce her mother's breast when she wants it. As Winnicott (1958) puts it, she learns to have "a belief in reality as something about which she *can* have illusions." But, Winnicott emphasizes, this is a necessary illusion that protects us from disabling anxiety, and to the extent that illusion has been challenged and perhaps shattered by the storm, you all have had a taste of that disabling anxiety. One of Winnicott's contemporaries, Ronald Fairbairn, had another way of describing how important it is to our sense of wellbeing to believe that we have control over our lives. He wrote: "It is better to be a sinner in a world ruled by God than to live in a world ruled by the devil" (p.66). In other words, Fairbairn is arguing, it is safer to believe that our parents are in the right and that we are defective, than to believe that the parents on whom we depend are not reliable and do not have our best interests at heart—and, by extension, that the world on which we depend can strike such indiscriminate and mortal blows.

This fundamental invariant of core self experience, the sense of being the author of one's actions, is initially acquired through motor behavior. Control over motor behavior is often lost during the moment of trauma. People say things like, "I was frozen in place" and "It was like a nightmare where you want to move but can't." Others will talk about operating on automatic pilot, taking the necessary steps to protect themselves but without having thought about them on a conscious level. This necessary dissociation defends against terror.

Those of you who are familiar with Melanie Klein's work—I'm thinking particularly of the way that Thomas Ogden (1990) interprets Klein—will recognize that the feeling of having no control replicates what she calls the paranoid schizoid position where the self exists only as an object; the subject who makes choices and follows through on them is lost. But paranoid schizoid reality persists once the immediate need for psychological escape through dissociation no longer exists, for the survivor finds that she cannot escape the intrusive memories and thoughts common to posttraumatic states. Once again she feels she has no agency. The paranoid schizoid self is chronically plagued by persecutory convictions. In this state, thoughts, feelings and perceptions are conceived of as constituting things in themselves. There is no subject, no self, no "I" to create and give meaning to experience; instead experience is driven by sensation. State dependent traumatic memories, prompted by a sound, a smell, an affect, a visual cue, a sudden turn in the weather, even a particular word, feel as if they are intruding, persecuting, unbidden, and uncontrollable. The survivor experiencing these intrusive memories, thoughts or feelings believes she is at the mercy of terrors over which she has no control.

The second component of Stern's core self is the sense of physical cohesion. The body is, quite literally, the site of the self. It goes without saying that there are many aspects of a traumatic situation that explicitly threaten the sense of physical integrity; implicitly those working with the injured and dead also find their own physical integrity threatened. However, our psychological boundaries (what I call our bodies-in-mind) can extend beyond our own bodies to include our homes, our neighborhoods, the entire physical surround. For some, the destruction of home, of a familiar environment, also threatens the sense of physical integrity.

This body-in-mind is subject to fragmentation and depersonalization when the psychic skin loses its reassuring and consolidating embrace. And skin *is* the literal divide between self and other, between inner and outer. The psychic skin is a container, capable of establishing an

interior object world inhabited by a benign object and capable of recognizing the separateness of others. As with the sense of agency, once the cause for alarm has ended, the body continues to register fear and continues to suffer the consequences of that fear, and psychological boundaries no longer feel secure.

The sense of time, what Winnicott calls “going on being,” is also doubly affected by trauma. During the immediate unthinkable anxiety, temporal dissociation is frequent, a fugue state possible. People say things like, "Time stood still" and "I felt as if things were happening in slow motion." Later, with the traumatic shortcircuiting of normal integrating memory functions, time continues to stand still long after the event. There is no longer past, present and future; the traumatic event itself does not become history, it is an everlasting and recursive present. Joy Osofsky quotes one first responder telling her, “I know what day it is. Every day is the day of the hurricane.” And one of the psychotherapists I interviewed told me that when he finally got back into his office and was able to resume his practice in late October 2005, he found that he had dated his notes August 2005. Time had not moved on since the hurricane.

Recurrent memories, so common to posttraumatic states, that intrude in apparently random fashion—often triggered by a smell, perhaps the smell of sodden furniture or decaying garbage, a turn in the weather, the possibility of another hurricane—also serve to keep survivors in the grip of the fall of 2005, rather than allowing them to move on to the present day. Intrusive thoughts interfere with the capacity to be reflective, keeping survivors highly reactive to internal phenomena generated by the memories and making the sense of continuity difficult to achieve.

Catastrophic dissociation is most frequently associated with numbness. Time and again survivors will say that during the traumatic event they ceased to feel terror; in fact, they weren’t aware of having any feelings at all. But some have found that the numbness endures after the catastrophe has ended; it alienates the survivor from all that is familiar. One of my favorite poets from World War I describes the lost intensities of hope and fear, never again to experience the feelings he remembers from before the war. Without familiar feelings to guide her, with traumatically disrupted internal patterns of arousal, and her failure to register subjective self states affectively, the survivor has lost her sense of continuity, becoming unfamiliar to herself.

The self who experienced a range of feelings is gone, and with it the ownership of experience. No longer punctuated by affect, life has becomes rote. Not only current experience, but memories too are devoid of emotional impact. Losing the ability to experience feelings in a consistent fashion leads not only to a loss of familiarity with the self, but this catastrophic loss has widespread interpersonal consequences. With the failure to register one's own feelings comes both the inability to share one's affective state with an other and the failure to appreciate the other's affectivity, which is the basis of intersubjective experience lying at the heart of our capacity to feel related to others. Not only does the survivor become more withdrawn, preoccupied with the intrusive memories and sense of being so changed, but frequently there is no one to speak with about what has happened because people expect you to have snapped out of it, as I was describing earlier in this talk.

So this brings us to another lingering, and painful, effect of catastrophic dissociation and one that you all mentioned—the loss of a sense of community. In the aftermath of a trauma, this loss of community is often a psychological phenomenon rather than an actual consequence of surviving the trauma. It is not unusual for survivors to believe that they are alone in the feelings of isolation and despair that massive trauma can generate, as if everyone else is getting on with their lives and the necessary rebuilding while they are alone in feeling overwhelmed, yet too

ashamed to share those feelings. As one of you wrote in a poem you sent me, "Always alone in a flood of circumstances." In the case of New Orleans, the physical disintegration of your community is quite literal and interacts painfully with the more individual and psychological sense of loss.

For some of you, Cormac McCarthy's novel *The Road* has become a parable for life immediately after Katrina. If you haven't read it (and some of you said you couldn't bring yourselves to finish it), it is a horrifying account of a man and his son making their way through a postapocalyptic landscape, where anarchy reigns, where there is not enough food or warmth or clothing and they are in terrible danger from marauding gangs. This was the worst face of New Orleans after the storm; frantic, starving survivors trapped in a city where no one was in charge or seemed to care, while rageful bands were looting and laying waste, as if every shred of fellow feeling had been lost.

Let me describe another community that was devastated by a flood. On February 26, 1972, one hundred and thirty two million gallons of debris-filled mud burst through a makeshift and faulty mining company dam and roared through Buffalo Creek, a close-knit community of five thousand people in West Virginia that consisted of several small townships spread out along the creek. Of those 5,000 inhabitants, 4,000 were left homeless, 125 died outright, and all of the survivors were exposed to the sight of dead bodies. Temporary morgues were set up. The National Guard was brought in. HUD assigned people to trailers without regard to their kinship groups. Does this sound familiar?

Sociologist Kai Erikson spent months in that community, working with the survivors and assessing the collective and individual damage. He documented the destruction that had, as he put it, torn the fabric of Buffalo Creek, just as the aftermath of Katrina, the failure of the levees, the looting, the chaos tore apart this community. He refers to this as a loss of *communality*. This is a step removed from the vivid terror of the event itself that many did not experience first hand, but everyone is affected by the loss of communality.

To Erikson, communality is the network of relationships that make up the general human surround. In some ways harder to identify than the individual losses, it is the fabric of life, the air we breathe, the familiar, the visuals. The guy from whom you buy your morning coffee, the mail man, your weekly meetings in church, the girl who checks out your groceries, your neighbors, your colleagues at work, the folks you smile at a couple of times a week in the gym, the house across the way or down the street, the comforting familiarity of your office, your home, your neighbor's home, your professional group. Like the sense of agency, the sense of belonging is often something you don't question until you have lost it. June Cross, who has just released a film called *Old Man and the Storm*, says that in New Orleans today people feel like immigrants in their own city. Immigrants face two enormous hurdles, the feeling of not belonging and the loss of continuity with the familiar life they have left behind. In this, I would say that most of you have gone through a period of being refugees in your own city.

With the changed face of New Orleans (the sense of uncertainty, the friends who have left, the professional associations that no longer meet, the routines that have been disrupted), "People have," as someone put it, "lost their navigational equipment, as it were, both their inner compasses and their outer maps." The sense of continuity, the comfort of belonging have been thrown into question. As Erikson describes it, you are

diminished as a person when the surrounding tissue is stripped away. He quotes one man in Buffalo Creek saying, "I don't have the same attitude towards people that I had. It used to be that I cared for all people, but not anymore. I just keep myself alive." Here you see how the larger loss of community becomes reflected in the individual psychological experience of isolation.

With that loss of community and the sense of isolation, the ability to communicate with others, to understand, to interpret, and to convey meaning is thrown into doubt. And this particular skill is of vital concern to us as therapists. How many of you have talked to me about Katrina brain? The feeling of fuzziness, not being able to trust yourself to think efficiently. One of the most experienced analysts lamented: "It took a while to start thinking about Katrina in psychological terms. I couldn't think about it. I couldn't do it. I didn't do it. That is really out of character for me. I didn't do it because I couldn't do it." And a young woman who was just beginning her career said, "You have to get your life together before you can reflect." And I've heard these words echoed by many of you: "That first year we couldn't get shit done anywhere. The simplest tasks took three times longer."

You aren't alone in losing your ability to think clearly. Whether the trauma has been community wide or individual, the capacity to think efficiently, symbolic functioning, is an inevitable casualty. Last spring I was invited to teach in the clinical psychology department at the University of Haifa. I was very nervous about that talk. I figured I didn't have much to tell Israelis about the aftereffects of trauma that they didn't know already. They live it every day. I was very moved by the reception I got. They welcomed my thoughts about massive psychic trauma. Here's what struck me so powerfully: While they all had questions about countertransference and technique, none of them could think beyond the clinical work they were doing. Many of them had fought in combat, all of them survived shelling from Lebanon and lived through the intifada. And they were working with patients who shared these experiences. In the face of an overwhelming reality, they had to adapt their clinical work, and they did, but they didn't know how to think about it. As Eliot says in *The Four Quartets* "We had the experience, but missed the meaning."

Researchers have provided us with evidence for this terribly disorienting state of affairs. In extreme stress, the flood of cortisol that is released during moments of sustained terror overwhelms the functioning of the hippocampus, whose job it is to consolidate memory. Traumatic memories therefore are quite literally short circuited and stored as somatic sensations, visual images, and auditory traces in the amygdala rather than being integrated through the mediation of the hippocampus and prefrontal cortex. Linguistic memory, which is crucial for symbolic functioning, is frequently inactivated during the trauma.

After a disaster of the magnitude of Katrina there is always a tension between acknowledging individual survivors' needs for recognition, understanding, and engagement on the one hand and the difficulty of absorbing the enormity of the destruction on the other. In the Gulf Coast during Katrina, 1,836 people died (that is not counting those who died in the weeks and months afterwards); 736 people remain unaccounted for; 275,000 homes were lost; 600,000 pets were killed or abandoned; 400,000 jobs were lost. When we hear these statistics, how do we also keep in mind individual lives, losses, and fears? But that is what you did. One of the most moving

messages that came through as I spoke to each of you was your understanding that you can only do this work one person and one action at a time. The task is overwhelming, but you bring to it the recognition that you are doing something crucial, keeping human connectedness alive in the face of impersonal state and federal machines. Immediately after the storm, some of you sought out chronically ill folks off their meds, hiding under beds in the FEMA trailer parks; you helped an elderly woman with a paraplegic son escape from the flooding; you watched out for families in the basketball arena in Baton Rouge, trying to keep them together, trying to ensure the buses they were randomly assigned to would go to the same place. You had to find the time to recognize and respond to the individual needs, establishing a small measure of connectedness where you could in the face of this catastrophic disorganization.

Immediately after the storm some of you volunteered to work in the public sector. Several of you showed great ingenuity in cutting through, or dodging under, FEMA's red tape. Others used makeshift offices to provide for long-term patients and to make room for new patients who were themselves serving as first responders and needed help processing this almost unbearable work. One of you said to me, "Immediately after the storm we provided everything and nothing." I would say, rather, that the steadiness you did provide, even if you weren't entirely there, even if you had Katrina brain, provided your patients with desperately needed continuity. Your availability said, "We can continue to talk regardless of where we are and what has transpired. Emotionally, I will try to be here. Even if we've both taken a beating, we can continue to reach out to each other."

Most mental health professionals have not been formally trained to work under these conditions. But one experienced therapist found that she was nonetheless prepared by the work she had done until then. "When my supervisees tell me they don't know what to say when someone tells them about their storm experience, I say, 'You don't have to *say* anything. They need to tell their story.' I'm teaching them to be there, be present and to listen, which is what we do every day."

At that time, immediately after the storm, some of you found that working was a refuge, restoring a sense of self, a sense of familiarity, and, of course, some agency. As one man told me, recalling his relief when a patient reached him by phone after the storm, "I thought, thank God someone in this universe knows I'm a psychoanalyst." Others were understandably too concerned that their own losses and horror would invade the treatment situation and decided not to return to work immediately. Knowing your own limits is one of the most important messages I can convey to you about this difficult work.

At first, some of you felt you were operating on automatic pilot, doing what had to be done. But as time has moved on, as the city has moved out of crisis mode and, many believe, out of recovery mode as well (though some believe you will be in recovery mode forever), the questions about your work get louder. "It's much harder for me now, when I am working with kids and families who are still going through this," one woman said. "With new patients it is sometimes difficult to listen through that starting process and all the pain they're dealing with, to have to go there all over again."

Vicarious traumatization, finding yourself traumatized or re-traumatized by your patients' narratives, is a common problem in this work. And it is so much more so when you have shared the trauma. For one young woman, who gave birth to her first baby

during the evacuation, hearing about families separated from their children is almost unbearable. "I just don't want to go there," she says.

Paradoxically—and inevitably—in this work in which we strive to bring a sense of connectedness to our patients, the necessity of maintaining a measure of professionalism can leave us feeling isolated. Forming groups with trusted colleagues, sharing the fears and sadness that this work can entail is crucial.

One therapist reported such a telling anecdote about her worries in returning to work after Katrina that it sounds like a metaphor for everyone's concerns about this work—not just immediately after the storm but right up to the present time. She asked herself, "When people have to scramble over tree limbs and downed power lines to get to my office, how can I provide a space for them that's safe?" This said so much about the extraordinary circumstances in which you were practicing—and continue to practice—in this city, in which to a greater or lesser degree your physical lives have been transformed. And not just yours, but your patients as well. It's not just how was the storm but what is it like coming back, living here, making a decision to stay when every small task for you and for me has taken on so much more freight. In her concern that she literally cannot provide a safe space in which to meet her patients, I also hear this therapist asking, "Am I doing this right? Will I make it worse? My patients know I had to scramble over these same tree limbs to get here. The usual therapeutic boundaries are topsyturvy. What can I let her know? Do I want her to know it? What if she's doing better than me, or making out better with FEMA? As a therapist I'm supposed to be OK. Am I OK? Am I recovering from the storm or just pretending? What am I bringing into treatment sessions from my own life? Does anyone else feel this way?"

I want to finish this talk by going back to the McCarthy novel I referred to earlier, *The Road*, because despite the explicit despair about human nature that it contains, there is another message to be taken from the awful postapocalyptic world McCarthy is describing: that is, the father's love for his son and the son's love for his father. This sustained each of them, and when the father couldn't go on, there was another family who could take over. Out of the horror, what is sustaining and leaves the battered reader with a fragile sense of hope at the end of this novel is the love between the father and son, and the promise that there will be a community to give comfort and protection to the little boy. You continue to do this every day. Seeing your patients, offering continuity, helping them reach out to others, asking yourselves "When I have shared so much hopelessness with my patients, how do I address it with them? How do I take care of myself? How do I reach out to colleagues? How do I attempt to restore a realistic sense of hope in the face of this knowledge?"

I wish there were clear cut answers, but coming together to ask the questions must be the first step.

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