

First published in Free Associations, the Newsletter of the Michigan Psychoanalytic Institute and Society, Vol. 36, No. 1, Feb 2006.

Disaster Mental Health Work in Louisiana after Katrina

Alan Krohn, Ph.D.

Psychoanalyst, Michigan Psychoanalytic Institute
Adjunct Clinical Associate Professor of Psychiatry
University of Michigan Medical School

After receiving disaster mental health training a few years ago through a joint arrangement between the Michigan Psychoanalytic Institute and the American Red Cross, I volunteered and was deployed by the Red Cross to Louisiana to join others in providing mental health aid both to evacuees from New Orleans and to other volunteers. The experience was demanding and very rewarding. While providing something different than psychotherapy, psychoanalysts and psychoanalytic psychotherapists can use their knowledge of personality and other skills to enrich disaster mental health work.

Disaster mental health typically emphasizes helping victims establish pre-disaster functioning. Part of this involves helping victims recognize that what they feel to be extreme responses in themselves are normal reactions to abnormal situations. While mental health workers are guided not to probe into troubling or traumatic experiences, they are certainly ready and willing to listen to victims, if they have a need to talk about what happened to them. This is very helpful guidance.

I found, in addition, that analysts' and analytic therapists' well tuned listening skills, along with their model of the mind, can help them make a particular kind of contribution to disaster mental health work. Mental health professionals with other orientations, of course, bring other strengths to their work with disaster victims. Our understanding of the effects of loss, especially in children and adolescents, helps us to be especially well suited to work with people who have undergone losses. Our understanding of ego functions and defenses also equips us well to strengthen defenses and coping modes that have been shaken by a disaster. We can also be alert to problematic, maladaptive responses to a disaster. A psychodynamic

understanding of the self and identity aids us in conceptualizing a disaster's assault on the self.

The Katrina disaster was traumatic, in the classic sense, because the external world and the victims' affective responses to it had become in a variety of ways overwhelming. As well, it destabilized the narcissistic equilibrium of many evacuees, leading their sense of self to grow shaky and diffuse. Many evacuees lost virtually everything -- homes, communities, jobs (and any prospect of finding new ones), contact with family members and friends. Some were then thrown into horrendous environments such as the Superdome or Convention Center or into more benign, but nevertheless, de-individualizing, shelter environments for extended periods of time. Many people in the shelters became passive, slept a lot, and drifted around with what people came to call the "New Orleans stare." I found in working with people who had lost so much that these losses and dislocations undermined their feeling of self and identity.

I found it useful, as I have with some adolescent patients, to draw on what evacuees told me about themselves and their lives before the disaster essentially to remind them of who they had been and still were (including modes of coping they had and could now revive). From a psychoanalytic point of view this is an effort to restabilize and refuel narcissism. It is, in essence, Heinz Kohut's mirroring. It involved listening carefully to what each person considered at a very core level to be important, valuable, and self-defining aspects of himself or herself. "You seem to be a person very committed to your family," or "telling great jokes is so much a part of who you are," or "having a really neat house and sticking to a project is very important to you," or "from all the rental places you owned, you seem like quite the entrepreneur." In conversations with people I would go into much more detail with them about these core personal qualities. I would say to them that sometimes when everything is ripped away from a person, it can make it hard to keep track of himself -- we forget who we are. This resonated with many people I worked with. This reflecting back was supportive in a general way, but it was more: it was an external affirming of basic aspects of their identity. This is similar to Bruno Bettelheim's observation that people in concentration camps who fared better psychologically were those who could hold on to who they were before life in the camp. In a way similar to the evacuees in shelters, people in hospitals or nursing homes fairly quickly lose a sense of who they are. A nurse once described this to me as "hospital psychosis."

While some disaster victims find it helpful when a mental health worker is globally and generally supportive by “normalizing,” it can make some (I would say many) feel that they are being given an impersonal, one-size-fits-all, empty reassurance. Even though analysts in a disaster environment are doing nothing like psychotherapy, our model of the mind helps us to approach every evacuee (or volunteer) in an individual way and to fashion a response that is specific to that person. It is this kind of approach that led a number of people to say to me (and the few others with a psychoanalytic orientation), “you’re different, you’re listening to me.”

I’ll illustrate this with an evacuee, who walked into a shelter in La Place, Louisiana, feeling suicidal and saying my head is “ready to explode.” She had just returned from New Orleans where she had seen her house for the first time since the storm. She had heard it was probably a total loss, but actually seeing it was something else altogether. Not only was her house destroyed, but a small building next to it where she had lovingly set up a small business was damaged beyond repair. Several people in her neighborhood had died (though none she was close to), and her entire neighborhood was “trashed and gone.” She said that when she talked to some well meaning “counselor,” he said, “you just need a hug.” While that is what some evacuees need, she said that was not what she wanted and needed. She described feeling that not only her world but “myself is somehow gone.” She also said she felt guilty about even complaining, it seemed unChristian, others were suffering more. She was clearly a person who relied heavily on God, but from how she talked I could tell she also prided herself for being very self-reliant and organized. Her way of speaking and holding her body also spoke of a need for control, a perfectionism, and a need to maintain a safe distance between herself and others.

This was a quick thumbnail assessment of her. Based on my understanding of her ego, her sense of self, the narcissistic assault on her identity, and her severe superego, I said supportive things about her belief in God, but suggested that maybe she was being extreme in her self criticism: that based on what she had been through it seemed fair and reasonable to lighten up on herself for acknowledging her suffering and needing to talk about it. I was here being an auxiliary ego and superego for her. She felt bad, too, that she couldn’t even think about going back to work, and I said that that would likely change down the road, but it was too much of a burden to be thinking

about that now. I said she seemed to be the kind of person who has very high standards for herself and can get down on herself when she doesn't reach goals quickly. And now the reality is nothing is going to be accomplished quickly. Drawing on my sense of her as having a more compulsive ego style, I also suggested she make a list of things that needed to be done and to do them one by one. I also reflected back that she seemed from the way she'd set up her business to be a resourceful, energetic person who sets goals and accomplishes them.

She was also concerned that she did not have her usual enthusiasm for her grandson, and I explained that right now she is in a mode of protecting herself and her family, really an emergency response, not having the emotional room even for enjoying her grandson. She certainly was looking out for his welfare, but it seemed unreasonable right now to feel she should be enjoying him. This was all directed to her perfectionism and the tendency to be overly self critical that was part of it.

She said after we talked that she felt much better, but I said I would like to see her later in the afternoon. She said she would return and would have pictures of her house developed by then. She'd like to show them to me. In the second meeting a lot of the work we did was while looking at these pictures.

With her and others I found what I learned from Henry Krystal's work on affects very helpful. I talked with her about the challenge to just tolerate feelings, to allow herself to feel them, and to moderate them. I said that feelings, even if strong, will not hurt her. She came in saying she felt her head would explode with overwhelming feelings about her home, job, a disabled husband, pressures of living in a shelter and other challenges of now living in close quarters with her family. People such as her who have the inclination to be in tight control find even their own feelings to be incipiently traumatic. This results in an experience that both the internal world, along with the external one, are or soon will be overwhelming.

While I talked with this woman for longer than was typical, there were many contacts where I tried, on the fly, to quickly sketch out what each person was about in order to better support strengths, to deal with personality weak spots, and most of all, to work to remind each person of who they were in the absence of external definers.

At the shelters I introduced myself to people and then stopped by daily to say hello. In some cases they wanted to talk about the trauma of the hurricane and its aftermath. The following vignettes illustrate how vital Freud's prestructural concept of abreaction is to disaster mental health work.

I talked to a man whose mouth was painfully wired closed due to an injury incurred during the hurricane. As the water rose, he ended up in his attic with his dog, as his house disintegrated under him. He finally broke through the roof, waited in vain to be rescued, and then left food and water for his dog before swimming away and being rescued. Unbelievably the dog was later found alive, and they were reunited.

A woman who had been a deputy at a New Orleans jail talked of being told before the storm that she couldn't leave her job. She ended up for five days with prisoners on an expressway ramp with no food and little water. She saw people die trying to swim away. By her account, three days before the storm, prisons inland offered to take the prisoners from her jail, but the administrators of the jail and city officials refused the offer. She talked of being terrified and ventilated other feelings.

A woman in her late sixties talked about the three days of "hell" she lived through at the Superdome, witnessing rapes, being awakened by gun fire, and living in filth. She was sure she would die there. She had classic PTSD symptoms and a powerful desire to talk of what she had witnessed.

As important as working with evacuees was working with volunteers or groups of volunteers, the Red Cross philosophy being that a volunteer will be able to perform her function better if her own mental health issues are not interfering. As I and the other disaster mental health workers were living in staff shelters with other volunteers, we were available virtually 24 hours a day for informal mental health contacts, whether it was with someone sleeping on the cot next to us or in the breakfast area in the morning.

A young volunteer doing logistics came up to me in the shelter's parking lot and talked about his demanding job and the flack he was getting for making reasonable requests of other volunteers. A few days later, at his request, I went along with him, when he took another volunteer to be flown out from New Orleans. The latter, a cook, had gotten into a bad situation with a shelter manager (not a shelter I was in); to compound things the man's ten year old son was having an emergency appendectomy in Denver that day.

The New Orleans airport was almost completely empty. It was an eerie, surrealistic experience for me and the logistics volunteer and was palpably raising the anxiety level of the volunteer being evacuated.

I helped a shelter manager reality test about the effects of his management style, including pointing out to him that he seemed to get tough and militaristic at times when he was, quite naturally, frightened (such as one night when there was only minimal security).

I worked over breakfast with some volunteers on how their anger at the Red Cross was becoming a preoccupation that was distracting them from their primary goal: to help the evacuees. In this connection I explained that many of us who volunteer have wishes to rescue people. When these wishes are frustrated, we can get angry, even at the evacuees. Sometimes we can get depressed and want to leave (as several people had the week before I arrived and one whom I was talking to was on the verge of doing). This was essentially interpreting a preconscious or unconscious fantasy and working with the ego reactions when the fantasy is disappointed.

An asset we have as analysts and analytic therapists is self analysis. Self analysis is extremely important in an environment that is unfamiliar, unstable, and when there are constant, complex demands being made on the mental health volunteer. A few illustrations of my own work with myself: When I thought I was not being assigned to the area closest to New Orleans, oedipal feelings of being excluded from the world of exciting adult activity were stirred up in me. On another occasion I was assigned to provide a mental health presence in a shelter that had actively refused it. When I called to make contact with the shelter, an older head nurse said everything was just fine, no problems – we don't need you. My supervisor told me to go anyway. I needed to work on my feelings of going up against the shelter nurse, who I was experiencing as a rigid maternal figure who might reject or demean me, while also wanting to please the supervisor whom I respected. I went to the shelter and within ten minutes witnessed and intervened in an incident of physical abuse of an undermedicated ADHD boy. I also talked to several severely traumatized adults (including the woman mentioned earlier who had been at the Superdome) and a very angry and depressed man who had lost his trailer and was unwilling to go into a temporary dwelling in what he considered to be a bad section of Houma. I also worked with myself around needing actively to approach people in the shelters and to

start conversations with them, something I am prone to experience as intrusive.

Doing disaster mental health work is, in my opinion, helpful for analysts. Because of the patients we typically work with, we can lose track of the effects of ongoing severe, current environmental trauma and deprivation. Also we can lose sight of direct, immediate, powerful emotional forces as we journey through the subtleties of defenses, id derivatives and compromise formations in the relative calm and quiet of the analytic situation. Disaster work can loosen us up emotionally and help us be better analysts and therapists.

This work is also a helpful antidote to an occupational hazard of analysts: narcissistic overvaluation of our technique, our theory and ourselves. Being the object of powerful transferences in the analytic situation, along with self-idealizing compensations for what are the limitations of analysis that many of us refuse to face, some of us come to worship our work, make a fetish of technique, and narcissistically overvalue our professional selves. Working in a crisis environment, where everyone is called by his first name, degrees do not appear on nametags, and where one may be called on to clean up after the odd overflowing toilet in the middle of the night can be a helpfully grounding experience for us.

I found this experience to be very rewarding and felt in some small way we did some good. Doing this kind of work demands living very simply (in church shelters on cots), being flexible, staying aware of the social and political forces at work, tolerating some risk, and being self reflective under pressure. Caring, empathy, warmth and general clinical skill all serve a mental health worker well in a disaster environment. To those I would add a psychoanalytic outlook.

Ann Arbor, Michigan
February, 2006