From 9/11 to Hurricane Katrina: Helping Others and Oneself Cope Following Disasters

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There are many psychologists who provided help to others following the terrorist attack of 9/11 and the natural disaster of Hurricane Katrina, but fewer who also experienced both of these tragic events first hand and also served others as a helper. This article is a personal account of a New York psychologist who endured 9/11 and then moved to Louisiana and endured Hurricane Katrina, and the personal and professional impact of these events. The unique and extremely challenging nature of the crisis work under these conditions is discussed, including techniques that seemed to be most effective for providing help to others, as well as techniques and behaviors that were helpful to the psychologist’s self-care during and following these catastrophes. The relationship to broader issues in the field of psychology and mental health is also discussed, including the ethics of psychologist self-care and practical recommendations for the providers of disaster mental health services.

Keywords: psychologists self-care; disaster mental health; Hurricane Katrina; 9/11 or September 11; vicarious and secondary traumatization

Tuesday, September 11, 2001. That morning was so particularly clear and bright. Not a cloud could be seen in the virtually pollution-free skies above New York City. I boarded the 5th Avenue Morris Park Express bus as I always did, on my way to work at Albert Einstein College of Medicine. I had worked at Einstein as a psychologist for about 5 years by that time, specializing in evaluating children with learning disabilities and providing psychological treatment for children with HIV.

As I sat on the bus that morning and looked out the window, I watched the world go by. Busy as usual in the Big Apple that morning with the hustle and bustle of folks on their way to work. Moms were pushing their kids in strollers; older children walked quickly on their way to school. Ladies and gentlemen sat sipping their morning coffee and reading the papers. The headlines were focused on the local New York elections for mayor and council leaders that were to be held in the coming day or two.

I closed my eyes and rested a bit while I listened to the radio on my Walkman, trying to gear up for the day ahead. As the bus left the borough of Manhattan and entered The Bronx, the scenery changed and became more industrial; grittier and grimier. Yet on that day, it actually did not look as bad because the day was so glorious. There were many 18-wheelers on the road and road construction was omnipresent. The bus stopped and started again as it navigated the rough terrain.

We were just approaching my stop by the hospital as I tuned my radio to the then Howard Stern radio show for some last minute laughs before heading into the harsh emotional reality of the HIV clinic . . . little did I know how harsh emotional reality would come to be on this day.

I heard Howard say something like, “Did you guys hear the latest? Someone just said that a small plane hit one of the Twin Towers? is this some kind of joke? What idiot wouldn’t see one of those Towers, they’re so glorious. There were many 18-wheelers on the road and road construction was omnipresent. The bus stopped and started again as it navigated the rough terrain.

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I heard Howard say something like, “Did you guys hear the latest? Someone just said that a small plane hit one of the Twin Towers? is this some kind of joke? What idiot wouldn’t see one of those Towers, they’re so huge?”

Now, Howard Stern is not a guy who takes much of anything seriously, so I have to say I was not that alarmed by his comment as I walked down the steps of the bus onto the pavement by the hospital. I took the headphones out of my ears and walked into the clinic. Boy, that’s sad, I thought to myself. Some poor guy obviously should not have gotten a pilot’s license and met an early demise, and maybe there was some damage to the World Trade Center (that is the WTC, for nonnative New Yorkers). This was
my train of thought as I got onto the elevator and went up to my office on the fifth floor.

As I got off the elevator, I began walking down the hall to my office. As per my daily routine, I put my stuff away in the room and then locked the door behind me to meet and greet the rest of the team.

The hallway was strangely quiet as I walked down toward the main conference room that was located on the southern side of the building, facing Manhattan. The conference room was especially bright as I entered the room, with the sunshine blazing in through the windows. On automatic pilot, I sing-songed “good morning” as I stepped into the room.

But it was obvious right away that something was amiss. Instead of everyone being seated around the table, my colleagues were all standing in front of the windows looking out. The silence in the room was deafening.

Somewhat anxiously, I stepped toward the window to see what they were looking at. I got closer and closer until I was able to regard the scene. I followed the eyes of my team members, who were staring into the distance, southwesterly toward New York City . . . and then my eyes caught the view. One of the Twin Towers was ablaze. From where we were approximately 25 miles away, you could see plumes of black smoke lifting up into the clear blue sky. People were talking nervously among themselves,

I heard it was a jet plane . . . how could a jet plane not see the Tower . . . this is terrible . . . oh no! Doesn’t your husband work in Tower 1? Someone get a radio . . . let’s go down to the clinic waiting room.

My eyes were transfixed to the scene and I was feeling very apprehensive. I wanted to call my husband in Queens and see if he knew about what was happening. Meanwhile, I heard my name being paged from reception—my patient was there and ready for testing. “I’ll be there in a minute,” I called. Someone from reception—my patient was there and ready for testing. “I’ll be there in a minute,” I called.

It was going to be really hard to focus on my patient knowing that something terrible was happening. A colleague’s husband worked in Tower 2, and

she grew faint and pale at that instant. We gathered around to comfort her . . . My head was spinning. I felt like I had to do something, but I did not know what. I left the room and went to call my husband on the cell phone and found out that he was all right, just very worried.

Then, I heard reception page me again to begin testing, and I knew that my patient was waiting. So I collected the child from the waiting room and brought her back to my office. On the way, I passed our friendly janitor who informed me that he had just heard that the Pentagon had also been attacked. My heart sank. I was barely able to control my state of panic. How was I possibly going to be able to focus on doing my job right then?

Somehow—to this day, I really do not know how—I managed to compartmentalize my tremendous anxiety for 45 minutes to give an IQ test. Somehow, I had to put all my fears and anxieties on hold and do my job, no matter how difficult, my ultrafirm professional, altruistic, and highly dedicated self-commanded, “Duty calls. You need to do what you’re here to do and take care of this child right now, and then you’ll worry about what’s going on at the Towers and the Pentagon later.” Now, in retrospect, I think that the intense anxiety about what was happening in the world around me was an impetus driving me to cling to something that felt normal and routine . . . In a way, I guess it forced me to distract myself from the horror of what was going on that morning. It is hard to know exactly how I did it, but I guess my temperament is such that I am very good at functioning when I am under pressure.

When I was finished, I walked my patient down the long hall, back to the clinic waiting room. It was eerily quiet in the hospital then, which was in and of itself kind of creepy. The clinic was usually so busy on Tuesday mornings. As we rounded the corner to the waiting area, which was empty except for the parent of my patient, I spied Dr. W., the director of our clinic, standing in the middle of the patients’ waiting room (a strange site because he never went into that room), in front of the television (this was also bizarre because Dr. W., an amazing and wonderful MD, was always on the go and did not stay put anywhere for more than a few moments), completely unmoving. First, I looked at his face—his profile—his mouth was open, his jaw dropped. I hesitatingly followed his eyes to regard the television screen.

And there it was. The awful, horrific, staggering, and unfathomable CNN headline: “Twin Towers Collapse Following Terrorist Attack.” The picture showed mounds on mounds of mangled concrete and steel in a smoldering pile where the Towers had stood just an hour ago, with incredibly huge plumes of gray and black smoke and dust emptying into the air, contaminating the perfect cerulean skies above lower Manhattan.

My jaw also dropped and I could feel my heart nearly stop beating. We had stepped into a surreal and new reality. Dr. W. turned to look at me and me at him. There was
sadness, confusion, and anger in his face and tears in his eyes. I did not know what to do or say but my expression mirrored his. I looked back at the TV screen just to make sure this was not some cruel sick joke. No. It was real alright. And the other scenes that they were showing, of the damage at the Pentagon, and of the remains of the plane that went down with Pennsylvania—it was too much to absorb. My heart bled and my mind reeled. How could this happen?!

The poignant mental snapshots of the hours/days that followed will always be with me: Photographs of beautiful everyday people who worked in the Towers plastered everywhere in the city—in the subways, telephone booths, and in bus stations—with family members desperately seeking their loved ones (these fliers read: “MISSING: TOWER 1—father of one, Cantor Fitzgerald Firm” or “MISSING: TOWER 2—beloved mother and friend, worked at Windows on the World”)—and New Yorkers stopped in their tracks, reading them, and silently or openly weeping; television and newspaper reports and images of those people who jumped to their deaths from the Towers to escape inevitably being burned alive; names and pictures of the hundreds (it’s still so hard to believe!) of firemen (343) and many policemen (23) who lost their lives (www.biography.com [9/11 database], 2001); riding on the elevated subway from Queens to Manhattan, staring out at the WTC site, still smoldering in the distance, with riders uncharacteristically talking directly to each other about the tragedy and comforting each other; and more heartbreak on hearing the news that two classmates of mine from my Long Island high school (Oceanside High School: Marc S. Zeplin—see www.marcezplin.com, and Jeffrey Nussbaum, the brother of a close friend, see http://www.cnn.com/SPECIALS/2001/memorial/people/3160.html) had perished.

In the days immediately following 9/11, like many psychologists, I was called on to provide counseling services to help other people cope with what had happened, and so I did not have time to process my own feelings and experiences. For me, this included crisis intervention and support services to patients and colleagues at the hospital, which essentially amounted to empathic caring and active listening (with hugs) to those who were very directly affected by the tragedy. For example, as mentioned previously, a colleague’s husband was unable to be contacted for many many hours because he worked in Tower 1, and so I sat with her for a long time to give whatever support I could. In another awful instance, another colleague had been in downtown Manhattan on jury duty when the Towers were attacked, and she witnessed the astounding horror of bodies falling from the buildings. I have to admit, when she cried, I cried. In that moment my sharing of her pain appeared to be helpful to her, but inside of myself, I remember feeling so bereft and inept to help anyone to deal with something so staggering. Even when I think on it now, these experiences seem surreal. I truly wonder if it is possible for a psychologist who is going through the horrifying moments of a natural or man-made disaster on a personal level can ever be in “psychologist: scientist/practitioner” mode much of the time, or does the experience of being a fellow victim/survivor level the playing field so much that it makes it unrealistic or unhelpful for the psychologist to be in his or her professional role? And who is to say what is more helpful to fellow survivors: relating on a professional or a basic human level? Based on my limited experience, this question remains unanswered.

Besides providing services to colleagues at Einstein and Jacobi Medical Center, I also felt compelled to volunteer to provide services to other New Yorkers who were affected. In my case, I ended up facilitating crisis support groups for two groups of approximately 50 workers in Manhattan who were in a building located adjacent to the Towers. It was a strange and extremely challenging endeavor, being sought out for counsel and professional services by other people during this time of incredible crisis—a crisis that had also affected me personally—I remember thinking how much I wanted someone to counsel and support me. This would prove to be an advantage from the standpoint of being able to empathize more genuinely with clients, and also a great disadvantage because the emotional toll that my own personal experience had left me much less centered and less capable of doing my job unencumbered. The rug had truly been pulled out from under my professional feet, and yet there were people with so much more suffering than I was experiencing who needed my help and I had to be there for them in whatever capacity I could—that is how I felt and that is how it was.

What follows here are edifying moments of my work as a psychologist aiding individuals in New York post-9/11 in conjunction with relevant material drawn from the research on psychologists’ self-care, personal ethics, and the provision of care to trauma survivors:

- Feeling overwhelmed by my own emotional experience made it hard to do my job well. At any given moment, I alternated between feeling a need to withdraw to focus on my own feelings and the need to focus on providing care and counsel to others. Ironically, despite my passion for the practice of psychology and my compassionate nature, this was a significant inner conflict.

Such a dilemma is nothing new, however, for psychologists. The body of literature on psychologists’ self-care has discussed the paradox of self-care in depth, and most recently in The Register Report, Spring 2008, in the article “Self-Care as Ethical Imperative” (Norcross & Barnett, 2008). In this
excellent article, the authors provide a wonderful analogy, derived from Stephen Covey’s (1989, p. 287) *The 7 Habits of Highly Effective People*, to highlight the irony:

Suppose you came on a man in the woods working feverishly to saw down a tree. “What are you doing?” you ask. “Can’t you see?” comes the impatient reply. “I’m sawing down this tree.” You exclaim, “You look exhausted! How long have you been at it?” The man replies, “Over five hours and I’m beat! This is hard work.” You inquire, “Well, why don’t you take a break for a few minutes and replenish yourself? I’m sure it would go a lot better.” The man replies emphatically, “I don’t have time to sharpen the saw. I’m too busy sawing!”

Now impose that identical encounter onto a typical practicing psychologist. You see the psychologist working feverishly evaluating, treating, and assisting patient after patient. “What are you doing?” you ask. “Can’t you see?” comes the impatient reply. “I’m helping distressed patients.” You exclaim, “You look exhausted! How long have you been at it?” The psychologist replies, “Over five hours and I’m beat! This is hard work.” You inquire, “Well, why don’t you take a break for a few minutes and replenish yourself? I’m sure it would go a lot better.” The psychologist replies emphatically, “I don’t have time to replenish myself. I’m too busy!”

If this is the dilemma faced by a psychologist on a “typical” day of practice (if there is such a thing), my experience was that it was increased 10 to a 100-fold during a time of great humanitarian crisis. The intensity and scope of the human needs were so incredible, that it drew me in so forcefully and so compellingly to help others. This was my mission in life; I said to myself, this is why I became a psychologist. Perhaps there was even some ego wrapped up in this self-statement of mission. It was as if I was going to prove to myself (and others?) what a seemingly heroic and strong public servant I was and to test my own ability to master my own emotions in a time of crisis. This was much easier said than done, however, when faced with the actual magnitude of the horror and the insidious impact of my own grief and trauma, from which I could not escape, even through my altruistic self-imposed call-to-action.

- Feeling driven to help others as a means of coping with my own experience was a major aspect of my experience at the time. In some ways, it was therapeutic to put focus purely on others while actively ignoring my own painful emotions. It was a useful way for me to get through that incredible crisis in the short term, although not necessarily the most psychologically healthy approach for the longer term. What I mean by this is that in the short term, compartmentalizing, denying, avoiding, and distracting myself from my own feelings of trauma and grief served me well to the extent that I was able to play (and even cling to) my helper role. That role offered me a temporary internal buffer against the experience of my own pain. But like soldiers coming home from war, when I “came home” to myself and left my role at the door, I was left with not only my own incredible grief and trauma, flashbacks, nightmares, and anxieties but also with the overpowering awfulness of the sights and stories of the tragedies of those whom I had counseled. So in essence, for me, a psychologist living through a crisis and helping others get through that crisis, the helper role was a sharp double-edged sword.

Here again, my experience was not one that is unique to psychologists to the extent that many of us feel gratified by helping others, and in so doing, this can help us to overcome challenges in our own lives, but at what cost to ourselves personally and professionally? There is an evolving area of research on secondary stress and psychologists’ need for self-care (Norcross, 2000; Norcross & Barnett, 2008; Norcross & Guy, 2007; Wicks, 2007) that delineates the myriad risks of focusing on the care of others at the expense of ourselves; I refer you to these outstanding works to read about this critical topic of self-care in more detail. Very briefly, these include acute and chronic secondary stress, vicarious posttraumatic stress disorders, burnout, and compassion fatigue. And then, there are other less “psychological” yet more tangible effects of failure to self-care that are equally if not more dangerous: Deleterious effects on relationships with family members such as our partners, children, colleagues, and friends (when we have given so much of ourselves all day and night to our patients that there is very little left to give and what is left is a physically and emotionally exhausted shell); or turning toward destructive ways to relieve the stress (i.e., abuse of substances, overeating, sexual improprieties, etc.).

These factors are highly pertinent to all psychologists (although in my opinion, many of us would like to bury our heads in the sand and disavow our own vulnerabilities), because they may serve to undermine and impair our professional skills. But alas, there is the ethical rub. One study cited by Norcross and Barnett (Pope, Tabachnick, & Keith-Spiegel, 1987)
found that 59.6% of mental health professional’s surveyed acknowledged “working when too distressed to be effective” even though many of them acknowledge knowing that doing so is unethical. Another subsequent study (Guy, Poelstra, & Stark, 1989) found that 74.3% of 318 psychologists reported experiencing substantial personal distress during the previous 3 years. Of those, 36.7% stated that it decreased the quality of patient care.

It is noteworthy that the aforementioned studies pertain to the impact of the personal stress of psychologists experienced as a function of the “typical” vicissitudes of life and not in the context of large-scale natural or human-made disasters. This certainly would be an important and new contribution to the evolving literature on psychologists’ ethics and self-care.

I do not know about you, intelligent and compassionate reader, but I find it alarming that as psychologists, we will admit to practicing in ethical quicksand, and somehow that is “safer” to us than taking a hard look at ourselves in the proverbial mirror and saying, “I need to take care of myself” or (heaven forbid) “I need to get help for myself.” It is as if we do not value ourselves enough or worse, our self-importance, greed, work-obsession, or hubris precludes us from delving into how the stresses in our lives can metastasize into professional (or personal) cancer.

Failure to take care of ourselves has serious consequences, as previously mentioned; ergo, this is much more than a just a cautionary tale. What can we do? It boils down to this: Dear psychologist, heal thyself! There are many self-care strategies that have been empirically documented which are worthy of closer examination and reflection as cited and described in much more detail in the previously referenced article by Norcross and Barnett (2007). These include valuing ourselves as human beings and being more self-aware, refocusing on the reward of the work, recognizing the hazards, minding the body, nurturing relationships, setting boundaries, restructuring our own cognitions and internal dialog, sustaining healthy escapes, creating a flourishing environment, undergoing personal therapy, cultivating spirituality and mission, and fostering creativity and growth.

- Figuring out how to handle the tremendous rage of those I was helping was very challenging. I remember that while counseling the group of workers whose office was in close proximity to the Towers that their rage and anxiety about what had happened was so great, I began to feel fearful that they might act out and possibly harm me. I am not sure if this fear was rational or irrational, real or imagined, but it was palpable. They knew that in comparison to them, I was an “outsider” being brought into their lives to help them to deal with their feelings about this tragedy, and so from their perspective, who was I to try to understand what they were going through, having witnessed people falling from those giant buildings and taking shelter from those ominous dust clouds when the Towers came crashing down. Even when I tried to empathize with the crowd through self-disclosure about what I myself had seen and experienced, many of the workers still regarded me with some degree of contempt. Despite knowing that their hostility was displaced, it was still real and interfered with my ability to help as much as I could.

Most of us do not spend even 1 hour or one semester in the classroom in graduate school learning about how to manage the behavioral challenges that emerge during crises. It is very understandable, therefore, that we can become anxious and realize how unprepared we are to deal with the highly charged nature of crisis counseling. This can occur even when we are faced with crises in our own offices, clinics, or hospitals. So imagine the additional challenge of being physically out of one’s comfort zone as psychologists are when providing help following disasters—being in an unfamiliar environment far away from our wall of diplomas and other pedigrees; miles away from our fancy leather office chair; possibly sleep-and-food deprived in the emergency shelter; and in cases of crisis counseling for survivors of catastrophic disasters, helping complete strangers who may be from very different walks of life than most of our professional clientele and who have just experienced unbelievable loss and trauma—and this could inevitably throw any of us off-balance.

There may be parallels from the area of research devoted to the study of psychologists involved in the treatment of trauma survivors (Chu, 1988) that can shed some light on the obstacles that are faced when working with people during large-scale crises. Important issues that I now only touch on but appear relevant and analogous include the questionable assumption of the presence of trust between the psychologist and the client in crisis; the delicate
balance of keeping enough emotional distance and boundaries between oneself and the client (particularly challenging when one has gone through the disaster on a personal level as well as on a professional level . . . it was nigh impossible not to overidentify with clients and difficult not to overly self-disclose); and how to navigate dealing with clients’ need for the protective mechanism of denial. In my experience, it was a combination of all these factors plus my own insecurity as an inexperienced and overwhelmed crisis counselor that may have heightened or even exaggerated my perception of being a target of survivors’ anger. Nonetheless, it still felt very real and disconcerting, and its effect was destabilizing.

• Things were so chaotic at that time in New York in the immediate aftermath of 9/11 that I was unaware of any network of psychologists to use as a touchstone for advice or support. New York City being such a large metropolitan area with so many psychologists, I never took it on myself to participate in any of the local or state-level psychological organizations beyond paying annual dues. I think this may also be a function of the “lone ranger” mentality that I had pre-9/11, in addition to just the busyness and demands of everyday life precluding my interest in involvement (I have since discovered that I was definitely not alone in this mentality, and that many psychologists, even colleagues of mine today, do not seem to feel the need to become involved in professional networks. In contrast, I have observed that social workers, perhaps because of the somewhat different nature, training, and conceptualization of their work, seem to participate more widely in their professional organizations.). This proved to be an error in judgment on my part that revealed itself in the days following the terrorist attacks. I found that there was basically no one to turn to for professional guidance and support. One of my dear coworkers at Einstein, a fellow psychologist, lost a close friend (his next door neighbor) in the attacks, and he was beside himself with grief and shock. I could not go to him as a friend/colleague to process my experiences or to get support from him because he just could not do it. Other colleagues who did not experience personal losses but were unable or unwilling to volunteer their services immediately post-9/11 were also not suitable individuals from whom to get professional support at the time. I remember feeling very alone, anxious, and confused. I relied primarily on my husband and family for support, which while valuable, is not the same type of support that one gets from fellow psychologists. Professional counsel, a network from which to reclaim a sense of normalcy for what I was experiencing as a psychologist working during a crisis, was, unfortunately, unknown to me at that terrible time.

After 9/11 and the birth of our daughter, my husband and I decided to move out of New York at the end of 2002. A professional opportunity presented itself in New Orleans, Louisiana. I had visited New Orleans as a child and recalled it as being a fun and festive city with a rich culture. I had some reservations about leaving New York because it had always been my home, and it almost felt like some sort of betrayal leaving the wounded city. Then, there was the anxiety-provoking issue of Yankees living in the south . . . It was a huge transition, but nevertheless we went ahead and made the move from The Big Apple to The Big Easy.

We established ourselves in our new home state and found Louisianians to be unbelievably gracious and welcoming toward us. We learned to love Cajun food, crawfish boils, and boudin, and our favorite, coffee with beignets at Café du Monde in downtown “N’Awlins” as the locals called the famous caffeine spot. A few years passed and eventually we bought a home in a town just outside of Baton Rouge and had another child, a sweet little boy. I had established a successful private practice in Baton Rouge and was also a clinical assistant of pediatrics in the School of Medicine of Louisiana State University. Everything seemed to be going along so smoothly, so well.

Then it was the end of August, 2005. It was even hotter and more humid than usual that summer. There had been many hurricanes that had developed that season, and we had grown accustomed to warnings. But this time, it was different. On August 29, 2005, there was an alert that Hurricane Katrina, which had already affected Florida, had reentered the Gulf of Mexico and was becoming even stronger. It was a Category 5 and on-track to hit the New Orleans area (although it had reduced to a Category or “Cat” 3 by the time it hit land; see Wikipedia, 2005, Hurricane Katrina). We were terrified, especially because as nonnatives, we had none of the complacency which comes from living all your life in a hurricane-prone area. We packed our bags and our kids and got in the car to evacuate. It took us 10 hours to drive 100 miles northwest of our home because of the immense volume of traffic along the hurricane evacuation route. We could not find even one motel with any rooms available and we must have checked 10 or so—it was a tense time. We were sitting in a fast food restaurant contemplating our limited options that night (sleeping in the car with 2 small children) when a lady came into the place passing out a flier for a local shelter for evacuees. We decided that was our only choice at that point, and so we went.
The shelter was in a tiny Baptist church in Chopin, Louisiana. The folks were incredibly warm and took great care of us and the approximately 60 other people who were there. We were all provided with cots/air mattresses/chairs in one large room together while the church members provided hot food and cold drinks. I do not think my husband or I slept an hour, although our kids managed to do so. We sat transfixed in front of the small television watching updates on the storm.

By early the next morning, the storm had hit. We called our next-door neighbor and he said that there was little damage in our subdivision although the power was out. So my husband and I decided to brave the remaining winds and rain and return home.

When we got home, fortunately, we did not experience any wind damage nor flooding at our house. Several homes in our area were damaged by fallen trees. We felt very lucky in comparison with those who had experienced property damages. We waited patiently for a few hours until the power went back on and then we put on the TV. The first news reports seemed to indicate that all things considered, New Orleans had weathered the storm pretty well. An area nearby, Slidell, had experienced more severe damage because it was closer to where the storm actually hit. Everyone, including the governor and other officials, seemed to breathe a sigh of relief.

But the next day everything had changed. The levees, which had been damaged by the storm and overrun by the water, had given way. The levee system was the critical system that kept New Orleans, which is below sea level, from flooding. Now that levee system had failed. Most of New Orleans became submerged. Hundreds of people drowned and tens of thousands were homeless. Folks climbed to the roofs of their houses in hopes of rescue that, if it came, came way too slowly in the dire conditions. Things just went further downhill from there. There were not enough supplies to sustain people in the main evacuation sites, the Convention Center and the Superdome. The heat was unbearable; many people died from dehydration and exhaustion. There was virtual anarchy in the streets and not enough police to bring things under control, so criminal elements took advantage of the awful situation. And as we all know too well, the response at the state and federal government levels was poor and contributed to further chaos, suffering, and death. Witnessing the failures of the government to step up to the plate served to intensify my feelings of outrage as well as the internal pressure that I felt to help those who were abandoned by the systems that were supposed to protect them.

So there I was again, back in the middle a nearly unfathomable crisis of humanity! The second crisis that I had personally experienced in less than 5 years . . . once again I felt compelled to act, to help. I volunteered for the American Red Cross and worked in hurricane shelters. Here are some highlights from that experience that I hope will prove informative to other psychologists:

1. The sheer magnitude of this natural/man-made disaster was incredible. An entire city had been devastated, neighborhoods gone, and ways of life probably permanently changed. Taking in this fact was important and informed my reverent attitude toward those whom I had helped. Even though for me 9/11 took more of an emotional toll on me (as a native New Yorker and because of the personal losses I had experienced), I tried hard not to compare these two experiences too much and was also very careful not to disclose my 9/11 experience to the people whom I was helping, because the two tragedies were really quite different. Although 9/11 was a human made disaster that challenged my basic belief in people’s good nature because of the intentionality of the evil, Hurricane Katrina was (predominantly) a natural disaster which was worsened by human errors (i.e., denial of the risk entailed in building a city that lies below sea level without a properly designed and fortified levee system; questionable planning and execution of a large-scale evacuation of many poor persons without access to transportation; the failure to properly prepare temporary housing for a population in ill-equipped and understocked facilities; and as previously mentioned, the insufficient mobilization of rescue and other assistance after the storm).

2. In some ways, having gone through 9/11 and being a helper in its aftermath made it easier for me to help post-Katrina. It is like that old adage that once you experience something really, really terrible, and you get through it, it just makes you stronger. I felt that my crisis counseling skills were sharper and I had more confidence in my ability to handle the stress of being a helper during a disaster. This confidence buttressed my resolve to continue to help despite the personal and professional challenges.

For me it was also easier to be more objective during this crisis as compared with 9/11 because I was not a native of Louisiana. I still in some ways felt like a visitor, having only lived in the state for 2 years when the disaster struck. I felt very sad and angry about the tragedy, but it did not shake me to my core in the same way as 9/11 had. I think this is also because having been born and raised in New York, part of my identity was intricately linked to being a New Yorker. The Twin Towers and the beautiful distinctive skyline that they helped to create.
over lower Manhattan was a symbol of that pride, and it was proudly etched into my psyche. When they were destroyed it felt to me—as it did to so many other New Yorkers—like an important part of my identity had been taken away.

3. There were multiple levels of trauma for the victims of Hurricane Katrina that made helping them more challenging. In the shelters, many of the individuals that I helped had experienced not only the losses secondary to the hurricane but those who had stayed in the Convention Center and the Superdome also experienced additional trauma by witnessing the human suffering that they did, and in some cases, the witnessing of violence. There was a mother and son who had witnessed someone being shot and killed virtually in front of them, and there was another individual who witnessed a rape. These folks were multiply traumatized and it was challenging knowing how best to help them; it was overwhelming. Hearing their stories was so upsetting that I know that I experienced some vicarious trauma myself. I used many basic crisis counseling and disaster mental health strategies, including debriefing, direct outreach, disaster triage, and focused on helping to improve survivors’ cognitive and emotional organization (Cohen, 1986; Cohen & Ahearn, 1980). I reminded them frequently of how normal their reactions were given the traumas that they had experienced, and I remember how appreciative folks were to have someone not only who listened but also normalized their feelings of anger, horror, and grief. Helping people in as many practical ways (by finding a soft pillow and blanket to sleep on, a telephone book, or a cold drink) was also useful.

I also remember practicing some self-care while I was in the shelters, which was a lesson I had learned from my experience during 9/11 (and my failure to do so). For example, it was helpful to talk to other shelter workers or listening to music by myself in a corner for a little while or getting a cold drink or fresh air to keep my literal and figurative “cool.” This strategy was very effective for keeping myself emotionally fueled and better able to help in the face of the pain and suffering of the survivors.

4. Feeling safe in the shelters was a big issue for me. Many of the evacuees were frustrated and extremely angry about how the government had failed to assist them in addition to the unavoidable losses of homes or property that inevitably occur when a hurricane of such strength hits. There was no obvious security system set up in the shelters for the protection of either the residents or the workers (this may have evolved over time). This brought to mind the importance for psychologists to have some knowledge/training about working in potentially dangerous environments or high-risk environments during crises.

5. There are many different ways that a psychologist can help in a crisis. I recall one moment where I felt especially helpful in a concrete way. A mother and son had evacuated to the shelter, and the son had bipolar disorder but had left his medication behind. I was able to provide referrals and resources to the mother to ensure that the son would be able to get his medication. At the time, I remember feeling somewhat guilty about feeling good about helping people in this way—because providing concrete help during a crisis is so much emotionally easier (although certainly not less important, necessarily) than being an active listener to stories of trauma.

6. Being a helper linked to other helpers was helpful. Unlike my experience helping people post-9/11, because I had linked up to the Red Cross, theoretically I did have a network of folks to whom I could refer, touch base, and get support from. Although because of the incredible magnitude of this disaster and the number of people who had evacuated into Baton Rouge (there was an influx of approximately 250,000, according to local news reports originally came right after the storm and about 20,000 remain), in reality, everyone was very busy and there was little time or opportunity to receive help from anyone. The Red Cross was purely and undoubtedly stretched to its limits.

7. The suffering of colleagues took its toll. At my practice, I learned that the family of a clinical assistant had lost their home, and that assistant was emotionally distraught. Another psychologist had lost his practice in New Orleans from the storm damage. A third had lost her practice and her home, and relied on me for a great deal of emotional support. At my practice, I did my best to provide support and counsel to these individuals and others who needed it.

8. Previously established professional networks came in handy for me. The networks of psychologists in Louisiana (the Louisiana Psychological Association and Baton Rouge Area Society of Psychologists) are relatively small and are closely linked (as opposed to the huge network that exists in New York). The network immediately reached out to colleagues for support of each other and also for ways to help the community. This was
Based on my unique insider’s view of being a practicing psychologist who has experienced these human tragedies on personal and professional levels, I would like to conclude by providing the following suggestions to fellow psychologists, because not only must we continue to help others to make this world a better place but we also need to get help for ourselves in advance, during, and following these experiences to keep doing what we do best. Some may be more easily done than others, depending on where you live (big cities may be more challenging than small towns), how much you like to affiliate with colleagues (so many of us are “lone rangers”—often to one’s own detriment), and how receptive you are to being on the receiving end of help in any form that may take (which can be an issue of the ego when it really should be just a human issue):

1. **Before:** Be an active member of your state and/or city’s psychological association. Attend meetings when you can and establish working relationships. These will serve you well should a crisis occur because you will have a network of professionals (and hopefully, friends) to lean on when you may need it. The American Psychological Association and its Committee on Colleague Assistance (ACCA) is helping to provide and establish local and state chapters for colleague assistance that will also be an invaluable resource for psychologists with which to link, ideally before a crisis occurs, so that professional networks and relationships have already been established. All psychologists could benefit from special training or literature to refer to regarding how to practice good security measures in times of crisis in a community disaster, information that again should be read before something occurs. It is like the Boy Scout slogan says, “Be prepared!”

2. **During:** During a large-scale crisis, it is important for each psychologist to evaluate their own emotional state and to determine whether they are truly able to help others. As I previously mentioned, there were times post-9/11 when I really felt unsure of myself because of the traumatic event. Altruism and the title “psychologist” may not be enough to manage the incredibly high level of stress that occurs during a major catastrophe. It is so important to take a pause and reflect on whether you are able to do the work, and if you cannot—like my friend/colleague whose close friend died—do not feel guilty about it. At some level, I really think that we need to take care of ourselves first—that is an important lesson that I learned through these experiences. If it means talking to a spouse, a friend, a colleague, or religious mentor to process one’s own emotions, this is extremely important while in the middle of the crisis to stay as centered as possible and to avoid feeling isolated. Ideally, if you have already established your linkage to a local psychological association, then you can hopefully rely on your colleagues for support also, and they may also be able to provide concrete information to you such as resources in the community that you can then pass on to those whom you help; this can be particularly rewarding as a helper during catastrophe. Also, if it is possible for you to be a helper who is helping as part of a larger organization (the local psychological association or the Red Cross, etc.) as opposed to going out on your own to help (I really learned this because I had the opportunity to experience the pros and cons of both approaches), this will serve you well.

3. **After:** When the immediate crisis has passed, continue to seek counsel and support from colleagues and friends. Sometimes, there is a sleeper effect for helpers, because we are so immersed in helping others that we put our own feelings on hold or compartmentalize them, and then they can come back to haunt us—it is unfinished business that will not resolve on its own. Whether it is therapy for ourselves or turning to APA or a local ACCA program, it is critical for us to process our experiences on an ongoing and as-needed basis. There may be unresolved feelings of anger that arise, for example—this was a big one for me—after hearing the horror stories of those poor folks and knowing how the government failed in so many ways in both tragedies. Also, for me, I have found that anniversaries of these events are when painful emotions and memories resurface and can affect my ability to do my work. These feelings are natural but need to be addressed before they interfere with the psychotherapeutic process. I know of psychologists in Louisiana who experienced episodes of clinical depression after helping Katrina survivors, so awful and so painful was their vicarious trauma (in addition to their own personal trauma and loss). These colleagues never sought out professional help for themselves, for whatever the reason. For myself, after
9/11 and after Katrina, I sought counseling that proved extremely helpful for wringing out my emotionally soaked psyche.

In closing, I would like to thank you, dear psychologist, for taking the time to read this article and for allowing me to share my experiences with you. I really hope that I do not have to put my large-scale-crisis counseling skills into practice anytime soon (although the weather pundits are predicting a very busy hurricane season again this year, dare I say!).

I leave you with this final thought: When the going gets tough, the tough get going, and they get . . . help for themselves!!

References


