

PART IV

WHEN DISASTER STRIKES A COMMUNITY

It may happen on a day
Of ordinary weather—
The usual assembled flowers, or fallen leaves
Disheveling the grass.
You may be feeding the dog,
Or sipping a cup of tea

—Linda Pastan, in *Traveling Light*

THE FIRST three authors in this section bring us into their experience of working in the midst of tragic events. They each describe their efforts to maintain a therapeutic framework in the face of a global devastation that affects clinician and patient alike. Such large-scale catastrophes underscore the reality that we are limited in our ability truly to provide the protection and stability that we strive for in our ordinary clinical practice. No one is immune to unexpected tragedy—neither patient nor therapist.

In her chapter on the effects of Hurricane Katrina, Sylvia Schneller invites the reader into the post-Katrina world of New Orleans, challenging us to imagine the experience of being completely cut off from one's home, family, and community. She relates her personal journey through the destruction and gradual rebuilding of her home and her clinical practice. With aching clarity, she describes losing contact with each and every one of her patients. While some patients eventually return, the fate of many others remains unknown.

Schneller examines the spectrum of depression and anxiety one experiences in the face of a catastrophe. In its direct aftermath, it is impossible to distinguish between an expectable and universal response to trauma on the one hand, and on the other, the response of an individual suffering from post-traumatic-stress disorder. In the end it is clear that everyone, in one form or another, suffers the effects of overwhelming trauma. Schneller's reflections reveal that, even as the process of rebuilding unfurls, the fragments of ruin remain.

Billie Pivnick relates her experiences as a therapist in New York City on 9/11 and her subsequent involvement in the development of the memorial at the site of the Twin Towers. She describes her disorientation and dislocation on that day and her efforts to be present for her patients while simultaneously being bombarded by her own fears. Pivnick tells us about her work with a mother and her child who saw the planes hit the towers and witnessed their collapse. She contrasts this treatment with that of an American man of Muslim faith who had lived and married in an Arab country. Following 9/11, he returned to the United States, fearing for his life had he remained in the Arab village where he was living. He sought treatment around his conflicts as a Muslim American. Pivnick demonstrates how the events of 9/11 and her work with these patients reawakened traumatic childhood memories of her own.

Pivnick brings the reader in as a witness to these moments, pointing out that bearing witness to traumatic events is an essential part of the process of mourning and recovery. Traumatized mourners often experience guilty self-recrimination, which gives rise to a tension in their inner world between a never-ending search for answers and a nonverbal, largely somatic experience of intolerable pain and grief. She views the therapeutic relationship as a means of opening up what she refers to as "memorial space," creating a "metaphoric container—a safe space in which faint and dissociated memory traces can be etched more deeply; connected to other memories, feelings, and sensations; and then linked to symbolic meanings in imagistic or narrative form." This idea of a memorial space parallels what we have called the middle-distance, a space that allows for integration and narrativization.

Russell Carr relates his experience as a military psychiatrist during the wars in Iraq and Afghanistan. He writes about feeling isolated and set apart from his civilian counterparts. He experiences the war through the eyes of his wounded patients, feeling a complex blend of emotions, including rage and shame. As a result, he finds himself reluctant to connect with old friends,

neither trusting that they would understand what he had been through nor be able to bear the recounting of his wartime experiences.

Carr poignantly remembers the pain of seeing young men with limbs torn off, traumatic brain injuries, and PTSD. In the face of such horrors, he is acutely aware of his own helplessness and vulnerability. He points out the necessity of finding what he calls a “relational home,” where traumatic experiences can be processed and borne. Carr writes, “I mourn the loss of a fully integrated sense of time, where part of me is not trapped with a traumatic past.” In this way he captures how trauma ruptures the continuity of time—what came before and what comes after the trauma is permanently altered by events that shatter one’s sense of self in time and in space.

In this section’s final chapter, Robert Winer brings us full circle to the essence of our psychoanalytic work—that is, mourning what was and coming to terms with what will be. Whether patient or therapist, we are all caught in the inexorable progression of time and our growing recognition of its finite nature. In fact, all of life is organized around our struggle to reconcile ourselves with this awareness. Without such an awareness, we are unable to mourn, and our grief may become depression, rooted in a denial of loss that keeps us paralyzed.

Psychoanalysis, for Winer, is about mourning and the recognition that our time is limited. Within this frame, he suggests that we try to do the best we can—to take hold of every moment and experience life to its fullest. He writes, “Analysis manifests itself as the cure for great expectations. . . . Some things happen for no good reason, and others for deep and complicated reasons, and getting our minds around that isn’t exactly pleasant or satisfying, but becoming reconciled to the truth, as best we can understand it, is what’s possible.”

As analysts, it is incumbent upon us to enter into the world of our patients, to bear witness to their trauma and loss, and to help them make the world whole again. Yet, as we have seen in these chapters, there are times when we too have been swept up by the same disastrous forces as our patients. Then we must attend to our own grief while simultaneously providing a space to connect with our patients—one where they can begin to heal their wounds. It is in the context of this unfolding connection with another who listens and tries to understand that transformation can begin.

CHAPTER 12

BROKEN PROMISES, SHATTERED DREAMS, WORDLESS ENDINGS

SYLVIA J. SCHNELLER

THERAPISTS INVOLVED in a long-term dynamic treatment process commit to their patients, either verbally or nonverbally, that the work will continue until completion of the therapy. When something unexpected occurs, such as illness or trauma in either the therapist or the patient's life, the disruption of that process is frequently experienced as a broken promise. Often, dreams of a fantasized good outcome are shattered. This chapter deals with one such life situation: Hurricane Katrina and the levee rupture that inundated the city of New Orleans in late August 2005. All members of the community, patient and therapist alike, experienced a shared trauma, a trauma some researchers describe as apocalyptic.

THE SITUATION

On August 29, 2005, Hurricane Katrina and the subsequent levee failures interrupted my thirty-five-year analytic practice. All the citizens of New Orleans, my patients and myself included, lived through the sudden and complete disruption of citywide and governmental services, those considered usual and essential to the conduct of daily life. We either experienced at first hand or through television and media coverage the same chaos as did the rest of the country. However, the immediacy of the despair, lawlessness, and anarchy happening to our homes, to our city, and to our neighbors left us marked in a profound way.