

LOSS AND RECOVERY AFTER HURRICANE KATRINA

Michael J. Zakour, Ph.D., Tulane University

The summer evening that the author and his wife evacuated from New Orleans was the last day of a beautiful dream. They had lived a wonderful life together in this unique and amazing city. On the morning that Hurricane Katrina slammed into the Gulf Coast, a horrific nightmare began. Within a few weeks after their evacuation, alone in Florida and unable to locate or contact friends from New Orleans, the author's wife, Lori, was diagnosed with terminal cancer. Throughout the ordeal, ensuring adequate care for Lori was very difficult. Two months after her diagnosis, she died in New Orleans. It was support from family and friends that helped him care for Lori and find a vision for his future, a mission to help vulnerable people. After a disaster, survivors need assistance to rebuild social support and a meaningful worldview. Social work must provide leadership in ensuring social justice and recovery after disasters.

The evening in New Orleans was as beautiful as it had ever been. The sky was clear and the sun bathed the oaks in a roseate light. The Victorian homes along the avenue seemed as picturesque as ever. But it was our last day in the New Orleans my wife and I had grown to love. We had prepared our home for hurricane conditions, we had loaded one car with our most precious and needed possessions, and now we were passing St. Charles Avenue on our way out of the city and out of south Louisiana.

For us it was the last day of a beautiful dream we shared as a couple during our years in New Orleans. Lori and I had been married for a little over a year, and we loved each other dearly. We were living in a small house I had bought in the Uptown area, and we enjoyed our neighborhood. We had frequently taken advantage of the great restaurants and live jazz in the city, and had followed the local culture such as the Mardi Gras Indians. Lori particularly liked Mardi Gras and other events during a holiday season that seemed to begin on Halloween of each year. New Orleans was indeed a unique city, with vibrant traditions passed down through generations. These traditions had given meaning and hope to the lives of people who often had little access to material wealth (Smith, 1994).

Evacuation and Deluge

As a social work educator specializing in research on disasters, I knew that 90% of all evacuations do not lead to a worst-case

scenario. Most evacuations end after a few days, and residents are allowed to return to their homes. This was the case with all of the evacuations in New Orleans since Hurricane Andrew in 1992. I had known about the potential destruction to physical and social infrastructure which long-term flooding could cause in urban areas. I believed that this current evacuation for the approaching Hurricane Katrina would end the same way as the others. Even for a disaster researcher and educator, I always find it hard to believe or even to imagine the worst. But on Monday, August 29, 2005, thirty-six hours after we evacuated, Katrina slammed into the Gulf Coast and began to flood New Orleans. On that day, a dream ended and a horrific nightmare began.

Lori and I arrived in Clarksdale on the morning of Sunday, August 28, 2006. We had driven all night and now were exhausted. When a local citizen began chatting with us and told us that the winds of Hurricane Katrina were now up to 175 miles per hour, I began to fear the worst. I knew that the destructive power of the wind was equal to the square of its maximum wind speed. This made the hurricane at its maximum wind speed almost 50 times more destructive than 25 miles per hour wind. In New Orleans, even a thunderstorm with 25 miles per hour winds and wind gusts up to 40 miles per hour could knock out electrical power. We followed the news about Katrina, and CNN soon broadcast scenes of destruction. The flood walls around the drainage canals leading to Lake

Pontchartrain had collapsed and most of the city flooded. The agony at the Superdome and Convention Center, filled with tens of thousands of people who did not get out in time, was shocking. An armada of buses had been available to evacuate the stranded, and even Amtrak offered to help get people out of harm's way. Outside offers of help were ignored by the city, and the school buses ended up ruined because they were not used and were themselves inundated during Katrina. Communication was very difficult during the immediate post-impact period because no integrated communication system was available. A total of several million dollars in funding had been allocated by the federal government to help to plan for evacuation and to set up a state-of-the-art communications system in New Orleans. The allocation for evacuation planning ended up being directed to an unrelated purpose, and the communication system was only in its planning stages.

At first we were both angry when viewing the chaos, and our anger grew as days went by and no large-scale rescue attempt was made. Scenes from familiar neighborhoods revealed massive flooding and bodies floating in the street. Numerous authors and researchers, including me, had predicted such a catastrophe in realistic detail (van Heerden & Bryan, 2006). I felt sadness that we had been largely ignored, and the "Big One" caught the city unprepared. Preparedness from local to federal levels was clearly inadequate, and beginning on Tuesday, September 30, the city sank into chaos.

The same populations that I had shown in my research to be most vulnerable, such as the elderly, poor, and people of color, were clearly suffering tremendously and perishing in large numbers (Zakour & Harrell, 2003). Many evacuated people could no longer access the medical treatment needed to save their lives. Many others, stranded in local hospitals, could not be sustained and died of exposure to extreme heat and dehydration. The lack of a coordinated evacuation effort for the elderly in nursing homes or other institutions led to the deaths of perhaps hundreds of

individuals in the New Orleans metropolitan area.

When we realized that we could not return to New Orleans anytime soon, my wife and I drove for 24 hours to a Florida town where I knew I could rent an apartment. We arrived there on the first Saturday after the Hurricane had made landfall. Lori, concerned about my health, told me I needed to get some rest or I might get sick. In her job as a social worker helping low-income families, Lori seemed never to become ill or even catch a cold, and she had never taken a sick day. She was a dynamo of energy, one of the liveliest people I ever knew.

Losing Everything

After less than one week in our temporary home in Florida, Lori experienced severe heartburn. After taking antacids a doctor had prescribed only three days earlier, on Sunday morning she was in tremendous pain. We drove to a critical care facility by 8 a.m., and Lori was transferred to a local hospital for a CAT scan. At around 11 p.m. on Sunday, the attending emergency room physician told us that she had a mass in her abdomen which could be cancer. Although we both held on to the hope that this might be a benign mass, I was extremely alarmed and saddened. After successfully evacuating from Katrina, we were largely alone in Florida facing potential catastrophe.

Over the next four days in the hospital, I discovered that physicians on Lori's treatment team made rounds on an unpredictable basis between 8 a.m. and 10 p.m. I stayed in the hospital for over fourteen hours each day, trying to help my wife and to obtain diagnostic information from the doctors. The care at the hospital was not particularly good, especially pain management. My wife had to endure unbearable pain for hours until the attending physician could be contacted and a prescription sent from the hospital pharmacy. The hospital stay was chaotic, with each physician saying something different about the diagnosis. The team of generalist and specialist physicians, as well as the nurses, did not seem to be communicating with each other. Physicians rapidly performed their rounds so that they

could return to their independent practices outside the hospital as soon as possible. Lori was unable to get out of bed most days and was heavily medicated to control pain. My primary goals were to corner physicians to obtain information and to urge the nurses to adjust the pain medication when Lori's pain became unbearable.

We were able to watch CNN at the hospital, and saw the graphic pictures of chaos and the breakdown of social order, as tens of thousands of people stranded in the city scrambled to survive and be rescued. There were reports of massive looting and even sniping at police and hospital personnel as they tried to evacuate patients. Though there were few reports in the disaster literature of looting after disasters (Mileti et al, 1999), it was clear that New Orleans could be a major exception to this generalization. I began to think that the lack of social capital in Louisiana had long caused social cleavages in New Orleans, and perhaps looting after a disaster had resulted from this alienation (Putnam, 2000).

Lori was discharged from the hospital after four days. She had been told that surgery would be necessary to make a definitive diagnosis. We were able to schedule surgery for Thursday, October 13, in Florida. Calls to our hospital in New Orleans confirmed that they did not have the capacity for surgery. Both of us tried to remain optimistic. However, waiting in Florida, far away from family, meant complete isolation from face-to-face social support. Our families lived anywhere from the midwest to the mountain west. Phone lines were often jammed, and even cell phones with the 504 area code were usually inoperable. Also, we did not want to alarm family about Lori's condition until we had a definite diagnosis. We were unable to reach any of our friends, co-workers, or neighbors for months after the Hurricane. Lori was suffering a great deal of pain and was often on heavy doses of pain medication. Though I had studied the phenomenon of the breakdown of social support after a regional disaster, the personal experience of this isolation was more terrifying than I had imagined.

We were unable to locate and communicate with anyone from New Orleans

for over a month after Lori was initially hospitalized. My wife was remarkably courageous the entire time, but I felt as if I was lost and had lost control over many difficult events. Our health insurance companies offered us very little guidance, when they could be reached at all. This aloneness must have been similar to that of the families broken up after buses took evacuees to many different states in the U.S. Our situation was similar to the many individuals fighting cancer whose treatments were indefinitely interrupted after Katrina. These patients couldn't even find their physicians, and many physicians' patient records were destroyed by flooding.

On October 13, my wife was scheduled to have surgery. The surgeon was a person with an excellent reputation. I sat in the family waiting area while the surgery took place, and I waited for several hours. The anxiety was the worst I had ever experienced. When it was over, the surgery team met with me in a conference room, and I was told Lori had advanced cancer. When I was told the cancer was in stage four (the most advanced stage), I asked how long she had to live. A surgeon who had assisted in the operation somberly stated that she could live only a few years at most, and that there was no cure. Despite the crushing news, I walked to the parking garage where cell phone reception was adequate and made the painful calls to family members.

Evacuating Again

During her hospitalization from the surgery, two of Lori's sisters were able to visit us in the hospital. They were optimistic that she would fully recover and were a comfort to Lori. Both had to return to their jobs in other parts of the country before Lori's discharge. Lori was discharged on Sunday, October 17, and we were given instructions about contacting an oncologist in our local area in Florida. However, within a week after her discharge, she began to feel increasing pain. We had planned to evacuate for Hurricane Wilma, which was predicted to cause hurricane conditions at our temporary residence. The day of the planned evacuation, however, Lori was in unbearable pain. I again

took Lori to the emergency room, and she was admitted to the hospital. Despite her condition and the approach of the hurricane, I was not allowed to stay in the hospital with Lori overnight. I was forced to find a room in a nearby hotel. The area that our apartment was in was predicted to flood, so I moved our most critical belongings to the hotel room, evacuating for the second time in two months.

During this hospital stay, it became clear that the aggressive cancer was rapidly spreading, and the prognosis was grim. After the threat of Wilma passed, I returned to the apartment to find no flooding. Lori was discharged after about five days. I was feeling deeply depressed about the prognosis, but I tried to remain as optimistic as possible. I called several friends in New Orleans—and miraculously two were at home—and we talked about Lori's illness. It was unbelievable to all of us that such a healthy and active person like Lori could become ill so suddenly. My friends encouraged me to distract myself from the fear of losing Lori by helping manage her medical, financial, and domestic situation, and this helped me tremendously. Sarah, a very supportive friend in New Orleans, had worked as a hospital social worker dealing with end-of-life issues. She helped keep my hopefulness alive so that I could effectively help Lori.

Lori experienced increasing pain after she was released after Hurricane Wilma hit south Florida. She was admitted to the local Florida hospital again in early November. In the emergency room, the physicians were only able to retrieve fragments of her record. She was given a room, but everyone was confused about what surgery she had had in mid-October. No one had the chart information needed to diagnose or treat Lori. Several days later Lori markedly improved, and I left the hospital to run some errands. When I was gone, she was inadvertently sent for surgery. When I returned, I had to track Lori down and inform the surgery staff that she did not need an additional surgery given her improving condition. I knew how horrible this must have been for my wife, to suddenly be taken for surgery, to wait, and then after several hours to be taken back to her room. This and other mistakes and miscommunications convinced

me that we needed to be in New Orleans in a hospital we trusted.

Returning to Home and New Orleans

I had been told by my friend Sarah in New Orleans that an excellent local hospital with a cancer center had just returned to 80% capacity. Within a few days, I asked the attending physician to transfer Lori to this hospital in New Orleans. A primary barrier to this transfer was that there were no rooms currently available in the New Orleans hospital. Sarah and her husband, a physician at this New Orleans hospital, helped me in my effort to transfer. The local Florida hospital, however, said that the transfer would take days, and I informed them that the hospital in New Orleans would only hold any room that became available for 24 hours. Yet the work on the transfer seemed to move at a snail's pace (with an apparent lack of concern by hospital staff).

I began to call my wife's health insurance company to see if they could provide guidance for us in this desperate situation. The automated phone system for this company prevented talking to a live person, but I somehow defeated the system and was connected to a service representative. This person was extremely rude and unconcerned. He told me that the New Orleans hospital was not a provider and that care at this hospital would not be covered by Lori's insurance. He also stated that there would be no reimbursement for the medical flight to New Orleans. With repeated calls to the insurance company and the hospitals in New Orleans, I soon found out that the statements of this service representative were false. Several physicians had informed me that this particular insurance company had often attempted to delay life-saving procedures. I was soon to find that, although this insurance company pledged that all of our hospitalization expenses in Florida would be fully covered because of the emergency declaration for Katrina, there were tens of thousands of dollars of my wife's medical expenses that the insurance company refused to cover.

One night, about a week after the transfer was initiated, Lori called me at 10 p.m. and said a case work supervisor had told her a

bed just opened up in the New Orleans hospital. The next morning I rushed to the hospital where my wife was hospitalized to meet with the case managers. They reported that they had no record of an open bed. I was stunned and angry that my wife, on heavy and disorienting pain medication, was the only person told about the open bed. After my persistent urging, they searched for about 30 minutes and found the record, buried in their computer, of the available New Orleans hospital bed. I began to work to arrange for a medical flight to New Orleans and helped arrange for reimbursement for this expensive flight through several insurance sources. Twelve hours after I had arrived at the hospital that day, Lori was finally in the ambulance to take her to the airport, where she would be flown to New Orleans with her life-support systems, a nurse, and an emergency medical technician. Despite five tubes which she needed for survival and pain control, Lori had said she wanted to go to our apartment and help me pack for the return trip to New Orleans. The doctors and I had to convince her that this was not possible.

I packed up our evacuation possessions and drove to New Orleans, using mostly I-10. The devastation near the Mississippi Gulf Coast was incredible. The trees were denuded or knocked down. Signs were twisted, and the main bridge to New Orleans was badly damaged. The beautiful places that Lori and I had loved to visit along the coast had been demolished by the highest storm surge on record, over 25 feet. Consistent with impressions which disaster survivors frequently reported, it seemed like the end of the world (Gist & Lubin, 1989; Wallace, 1956).

The drive into New Orleans was equally disturbing. Most of the buildings were badly damaged, and most homes and apartments were unlivable. I arrived at my home after passing mile after mile of devastation. I was met by Sarah who, along with her husband, Keith, had been helping Lori to return to the hospital in New Orleans. My nephew, the son of Lori's sister, had driven down from Minnesota with Lori's father and sister. They met me in Lori's hospital room where Lori seemed to be getting somewhat stronger. While I was at the hospital, our visitors were

able to remove our destroyed and mold-filled refrigerator, which had been a wedding gift from my parents. The removal of the refrigerator paved the way for a cleanup of the house so that Lori could stay at our home if she was released. A widow from Sarah's church, on a fixed income, had donated a small refrigerator and some money to us. This small refrigerator allowed us to keep the liquid nutrition cool so that I could manage intravenous feeding if Lori could stay at home.

The visit from these three relatives was followed by Lori's brother and other sister. Lori was released the day before Thanksgiving. I quickly learned to manage the intravenous feeding process for Lori. Without this source of nourishment she would become dangerously weak. The rapid growth of cancer meant that it was stealing nourishment as it spread and grew. The illness at times made it impossible for Lori to eat. I was gratified that I was able to help manage Lori's care so that she could be at home for Thanksgiving. Lori and I had longed for a return to our home. Our families and friends did everything they could to help this happen. Sadly, Lori's stay was short. Because of increasing pain and an inability to eat any solids, Lori returned to the hospital on the Sunday after Thanksgiving. She had to again endure the terrible placement of a tube through her nose and into her stomach to reduce pressure on her stomach. This had been a feature of each of her hospitalizations, but this time it was particularly painful. I could hardly bear to watch this very painful procedure, but she was very courageous, more courageous than I could imagine a human being to be.

After her other family members had left, her mother flew in from the northwest U.S., along with Wayne, one of Lori's best friends from childhood. The hospital staff, Lori, and I knew that it was a race against time to help Lori regain her strength faster than the cancer spread so that she could receive chemotherapy. I asked both Wayne and her mother for their help in this desperate situation. I worked out a system in which I went very early to the hospital to meet the physicians during morning rounds, and then either Lori's mother or friend would stay with her in the

afternoon while I tried to tend to household and other business.

Early in December, I ordered a new refrigerator, and it was scheduled to be delivered in one month. The post office started to deliver mail again, although I soon found out that most of it was bouncing back and forth between Florida and New Orleans. I finally straightened this out, and we began to receive more mail. Ministers from Sarah's church were visiting Lori, too, and I finally felt that her medical care was less chaotic and more coordinated. It helped that both Lori and I had friends who were physicians at the hospital. The hospital was also one in which the physicians did not have an independent practice outside of the hospital; this helped greatly with the flow of information.

Lori rallied briefly during this last hospital stay. She was able to speak and move more energetically. Through her window, we could always see the skyline of the downtown and the Superdome, both of which were the scene of so much suffering and death during Katrina. The social worker tried to get Lori moved to a room overlooking the Mississippi River, but this never happened. After Lori's mother left, Wayne and I tried to help her get out of the room and around the hospital, and we were able to do this with a wheelchair and a tank of oxygen on wheels. We took her down the elevator to the hospital lobby, lined with paintings which she enjoyed. We took her to the atrium which has a beautiful fountain and sculptures. She enjoyed the change of scenery but was terribly weak and tired, even sitting in a wheelchair.

Wayne had to leave after a few more days, and I spent many hours with Lori each day. It was a triumph for us to use several buckets of water so that she could wash her beautiful hair while sitting on the bed. I had learned that massage could reduce the pain of cancer, and I tried to do this often. I tried to always be at the hospital when Lori had any procedure done, such as a test or minor surgery to temporarily relieve her pain. These procedures were frightening, and my presence was reassuring to her.

On Monday, December 12, 2005, we were both very saddened to learn from the doctors

that Lori would never be able to eat again, and would have to rely on intravenous tubes for nourishment. This meant that anything other than palliative treatment would be impossible, and Lori seemed to lose all hope at this point. Her arms began to shake unsteadily each time she raised them to adjust her pillow or reach for something to drink. We both feared the end was near. Incredibly, she tried to protect me as much as possible from the very bad news the doctors were now giving her. She was more concerned that I would be unable to go on after she died. I knew that her pain must have been great, but on a scale of 1 to 10, Lori always reported a number under 5 to her doctors. My sister and mother flew to New Orleans to help us out. But the night after my sister arrived, I was awakened by a call telling me that Lori died that morning at 5:30 a.m. We rushed to the hospital to see Lori lying in her bed with the life-support tubes removed.

With Sarah's help, we arranged for services at Munholland United Methodist Church, and it was a beautiful memorial. Many neighbors, friends, and co-workers, along with our extended families, were able to attend the memorial and dinner afterwards. Sarah, my mother, and my sister made most of the arrangements for that day. The attendance was so wonderful, given that many people had yet to return to New Orleans. Without the emotional and material support family and friends had given so generously, I don't know if I could have succeeded in helping Lori to feel loved and cared for during her terrible illness. During Katrina and the illness, it was family and close friends who made caring for Lori possible.

Battles with Insurance and Corporations

In contrast to support from family and friends, little or no help had come from the large insurance companies or the corporations charged with disaster relief and recovery. Lori's health insurance company had offered no guidance during her terrifying and rapidly progressing illness. They had given me only misinformation about coverage and payments. I finally learned that they had misrepresented the level of payment for providers in Florida,

outside of my wife's home network. They would pay these providers at a very low level, although Lori and I were promised by insurance representatives that the cost of hospitalizations and surgery would be fully covered as if all of the providers were in network and first tier. I was angry at being lied to by her insurance carrier.

I keenly felt many secondary losses related to Lori's death. When I had to have a procedure performed at another hospital that next spring, I felt terribly lost when I could no longer list Lori's name in case of an emergency. When I was lecturing to a class about clinical social work cases, I realized that I would no longer learn from my wife's professional experience as a social worker. Lori had been my life's anchor. I felt so lost without her love, companionship, and support. With so many landmarks in ruins after Katrina, while driving my car on once-familiar routes, I sometimes could not remember where I was. Lori had been my North Star.

Soon the humiliating calls and letters began arriving from collection agencies, demanding that I pay the out-of-pocket expenses immediately. I was treated like a criminal even as I was beginning to mourn both for Lori and for New Orleans. My mortgage company had given us a grace period because of Katrina, but now their computers were mistakenly indicating that I had defaulted on the mortgage. The company had sent a letter of default and repossession of my home in New Orleans to the Florida apartment, and it took a month to be forwarded back to New Orleans. Lori also had student loans which I assumed, and the loan company said that most of this would be forgiven if I sent them a death certificate. However, death certificates were delayed for months because the main vital statistics office had been destroyed during Katrina. After a month, the student loan company said that it would obtain Lori's death certificate for me. Yet, another month passed and I received a letter that I owed the company over \$80,000 in student loans, and it said a collection agency would seize this amount if I defaulted. I was afraid that I would lose everything, including our home, my automobile, and my life savings. With the harsh new bankruptcy law that had

become effective in October of 2005, I was unsure what could happen. I spent hours on the phone each day talking to these companies and collections agencies, trying to correct all of their mistakes. Finally, close friends suggested that I use a lawyer. Bruce, the lawyer who had created a will and living will at no charge for Lori weeks before her death, put us in contact with an estate lawyer who shielded me from these collection agencies. I was unable to grieve as I fought to regain my financial footing. I became very distressed as I had to repeatedly remind numerous companies that Lori had died. During phone conversations some of the customer service representatives were sensitive, but many times the representatives were rude or even tried to joke about Lori's death.

I was very busy at this time with a higher workload at the school to help students' resume their studies, and I presented papers on the vulnerability of populations in disasters at all of social work's major conferences. I was unsure if I would be able to do this so soon after Lori's death, but found that I could still speak in front of a large audience. My mentors and colleagues in social work education have been a tremendous source of support, and I began to draw on the courage that Lori had shown, not only to "remain standing," but also to move confidently into the future.

A Delayed Recovery

As the spring semester came to a close, I began to have more time to grieve for Lori and for New Orleans. I hoped that the long nightmare was coming to a close, despite the slow recovery for New Orleans. I continued to feel profound loss, and each day the local news media showed the unbelievable delays in recovery. Thousands of people had not received FEMA trailers almost a year after Katrina. Many people did not know the whereabouts of loved ones who had been separated from the rest of the family during evacuation. A year after the disaster, some families were just finding out that their loved one had died and that the body had been in a public morgue for months or a year. In hard-hit parts of the city, rebuilding had not begun a year after Katrina because many people,

particularly in low-income neighborhoods, did not have insurance that covered flooding.

Each week on the news, a story would come to the attention of reporters about the suffering of elderly people, such as one who recently had an operation for cancer but who did not yet have a trailer to recover in. Perhaps the story was about an elderly couple who were living in the demolished remains of their home waiting for a trailer, or it was about a family still living in a shed because their trailer had arrived but the keys to the trailer were still undelivered. In my own circle of friends, neighbors, and co-workers, many people had lost parents or other family members, either during the hurricane or because of the stress from post-disaster life. Almost everyone in the social work department where I teach lost a loved one, or had lost their home to Katrina. When I spoke about my experiences to friends from outside Louisiana during professional conferences, they were stunned by the extent of my losses. Yet, people living in New Orleans seemed to have lost much of what was important to them, and many were too caught up in their own losses to comprehend what had happened to their fellow citizens.

Many in New Orleans realized that they could replace their home, but they could not replace a loved one or friend. However, despite tremendous efforts to protect loved ones, they were dying at an alarming rate after Katrina. Also, for many people, it would not be possible to return home for a very long time. As of December 2006, over 80,000 households had applied for State aid to rebuild their homes. Even though this money was available from the State for most applicants, fewer than 80 households had actually received any money since the program began in August 2006. At this rate, the funds would not be completely distributed for at least a century.

When Katrina destroyed most places of employment in New Orleans, it destroyed access for most people to healthcare. Because most health insurance is based in the workplace, the large majority of New Orleans residents lost their coverage, or it was greatly reduced, because they were out-of-network during evacuation. This represents a severe problem for the seriously ill and those who are

in need of mental health services to cope with extreme loss. Many individuals suffering from severe post-traumatic stress have not had the means nor the resources to seek professional help. Several individuals in New Orleans provoked the police so that they could commit suicide through a police shooting. It is not known how many others have died through suicidal behaviors such as reckless driving or other accidents.

With no place to live in New Orleans, over half the city's population had not returned by the end of 2006. Even when residents were able to begin rebuilding in their neighborhoods, often a large percentage of their neighbors had not yet returned or decided to stay in another part of the country. Without residents, businesses are lacking in workers to return to post-Katrina levels of business activity. Without businesses fully operational, residents cannot even purchase basic necessities. Businesses are closing because they have no customer base, and even if residents could return, they have no job to come back to. It is not clear how this downward spiral can be stopped.

A Meaningful Vision of the Future

Numerous religious and media figures have commented on the greater meaning of the Katrina disaster. After the first anniversary of Katrina's impact, however, most people have stopped asking the question "Why has this happened?" More important are the questions "What are we to do now?" and "Where are we to go?" To move forward in my own life, I needed to construct a vision for a future without Lori, as well as a vision of meaningful roles for myself. Though I have been a student of disaster social work for over twenty years, I never truly understood how terrible the loss of life could be, and I had no personal frame of reference to understand tragic losses. I now have a fuller understanding of the needs of grieving people who have survived a disaster. I feel as if I am a citizen of the "nation of the wounded," in the words of Richard Rodriguez (Moyers, Rodriguez, & Houghton, 2006). The nation of the wounded is a polity for people who have lost a loved one, and it is where

those who have had a diagnosis of a life-shortening illness live.

There is a terrible sadness that comes with loss—a sadness not only from tragedy, but also from the realization that our time on earth is short. Sadness and fear come from the understanding that bad things don't just happen to other people, to those you see on the nightly news. But this sadness which never completely goes away is also part of seeing the world as it really is. No matter how well people in affluent nations are able to deny the reality of death, each of us will die, some out of season. This understanding is more realistic than the view of life as an endless celebration of material successes. Once one belongs to the nation of the wounded, one's best hope may be to grow into the role of the wounded healer.

Throughout this personal and national tragedy, I have struggled to reestablish a worldview appropriate for these new and often frightening circumstances. This process has been one of finding new meaning, and engaging in relationships and activities which are meaningful. It would seem as if all of the roles I formerly occupied have been swept away along with New Orleans as we knew it. If I had been unable to cognitively restructure my understanding of reality, I would have been left with nothing but emptiness and loss. A primary element of this post-traumatic growth has been my rededication to serving vulnerable people, whether it is the personal emergency of a cancer diagnosis, or the collective crisis of a large-scale disaster. My research, teaching, and practice in the area of vulnerable populations sustains me and gives my life new purpose. For me, the best alternative to relentless grief seems to be a purpose in life, a calling to serve others—a mission to honor Lori's courage and her service in helping distressed low-income families.

Themes from Disaster Losses

The high point for altruism? I had always accepted the idea that altruism was at its highest after a major disaster. The altruistic community is an important and durable concept used by disaster researchers (Barton, 1969). Supposedly, disasters bring out the best in people, as do personal catastrophes such as

a life-threatening illness. However, what I have experienced and observed after Katrina is more consistent with Dickens' opening line "It was the worst of times, it was the best of times." Crises reveal the true nature of individuals, relationships, communities, and institutions (Hoffman, 1999). Conflicts, for example, may remain hidden during non-disaster times. However, the flood waters and the wind of Hurricane Katrina swept away the pretense disguising divisions within communities. The intense poverty and deprivation of the inner city, the alienation of the old and ill, the racism which still damages the life chances of people of color, were all clearly revealed. Housing, business, and health insurance companies made record profits over the last year, even as they denied substantial numbers of claims and raised premiums by 50% or more. Because it has always been costly to coordinate medical care for seriously ill patients, the chaos which usually accompanies cancer treatment was compounded by a national disaster, and there seemed to be little advocacy for the seriously ill.

Missing expertise and disasters.

Disasters are not acts of God but acts of humanity, or perhaps the failure of humanity. The massive flooding in New Orleans was not caused only by the hurricane; it was also caused by inadequacies in the levee system around New Orleans. These inadequacies were well-known, as was the danger in the disappearance of the wetlands surrounding New Orleans. Almost as much as improving the levees, restoring wetlands could protect the region from hurricane surges. These problems have been understood and communicated by scientists and the media for many years. The inactivity after this knowledge was disseminated seemed to be a case of missing expertise in disasters (Rajan, 2002). It was also well understood that lives could have been saved if people were evacuated before a hurricane such as Katrina.

Coordination of care. The lack of coordination of community disaster efforts and of medical care for thousands of seriously ill

people caused a descent into hell after Katrina. I knew that adequate coordination was a rarity, both in medical treatment for serious illness and for community disasters. The extent of the chaos that ensued after Katrina, and during my wife's illness, however, was unimaginable. People drowned or died from exposure because of the lack of a competent evacuation and rescue effort (van Heerden & Bryan, 2006). Even in the smaller scale settings of a hospital, treatment teams did not communicate with each other, and I was forced to act as social worker and advocate for my wife, serving as a conduit for communication between treatment team members, family, and friends.

Delayed recovery and bureaucratic red tape. Anthony Wallace (1956) compared disaster aid and rehabilitation to gifts flowing from an inexhaustible source, a cornucopia. Though I had always assumed from the disaster literature that aid flooded in after a natural disaster, aid to New Orleans has been very slow to arrive. After Hurricane Andrew, for example, a number of communities were rebuilt in a timely fashion and ended up with a higher level of social and economic development than before Andrew. It took nearly four days after Katrina for rescue and other disaster response efforts to begin in New Orleans, and some of the households needing a temporary trailer did not receive one until over a year after the storm. Several neighborhoods in New Orleans have just recently received safe running water. These neighborhoods have not even begun to rebuild. This is certainly not the "phoenix effect" seen in other disasters, in which a community rebounds rapidly and better than ever (Dyer, 1999). In Katrina, aid organizations were too concerned with liability issues, and the stockpile of aid resources was not adequate.

Bereavement and the altruistic community. The realization of the true nature of reality helps one to realize that death is an inevitable part of one's life narrative. So few people have been comfortable providing support for the many people who are grieving over losses from Katrina. Outside of family

and friends, some people upon hearing of my losses, have become highly dramatic or histrionic, as if it happened to them. Others have just wanted to grill me for all of the horrible details. Some have offered a moral or theme for my suffering, and many of these themes are the most negative and hurtful interpretations possible. The surgical team which diagnosed Lori's advanced cancer seemed completely unprepared to inform me that Lori's cancer was aggressive and incurable, and instead they attempted a light-hearted approach which was intensely hurtful. Most frequently, however, people don't know what to say, or are afraid to say anything. Societal denial of the reality of death, especially the death of younger people, does a disservice to those who have experienced the loss of a loved one (Moyers, Rodriguez, & Houghton, 2006).

Trauma and social support. One of the themes of my research in disasters has been about the need to reconstitute social support in a timely fashion for disaster survivors. This is done through the efforts of human service professionals, non-mental health professionals who are disaster volunteers, and, most importantly, social support networks of family, friends, neighbors, and co-workers. I have been very fortunate in this regard. Beginning during our evacuation, our families and close friends rallied around us. For many other victims, families were torn apart, either through the evacuation process, or through the need for adult members of families to relocate to where their employment was relocated. Social support is extremely important in times of crisis and emergency, but often the social infrastructure has been compromised or destroyed by the very hazard which made support so necessary.

The disaster community. Events in New Orleans after Katrina have reverberated around the world, showing that disaster communities are not restricted to geographic places. In smaller scale disasters, many students of disaster assumed that victims resided in the local area impacted by the hazard (Mileti et al, 1999). After 9/11 it became

clear that the circle of victims was much larger. In Hurricane Katrina, the world was able to view the terrible suffering of vulnerable people, most of them older, or very young, or low-income people of color. Because of long-term displacement of survivors, and because the extended families of survivors may have resided outside of Louisiana before Katrina, the disaster community is global. The disaster and loss of my wife have been intensely stressful for our families of origin, who reside mostly in the northern U.S.; our disaster community is a personal community of interest, rather than one of geography (Norlin & Chess, 1999).

Loss and the search for meaning. I have written this narrative partly in the hope that some meaning and insight may arise from the ruins of my life and the rubble of Katrina. Although I have been a student of disaster social work since I earned my M.S.W. in 1984, I never truly understood how terrible the loss of life could be, and I had no personal frame of reference to understand tragic losses. As the Buddha said at Deer Park, birth is suffering, old age is suffering, illness is suffering, death is suffering. I now have a fuller understanding of the needs of grieving people who have survived disaster or loss of a loved one. To loosely paraphrase David Jones, a British poet who wrote about the carnage of WWI, the meaning is in the humanity, and humanity is in the meaning. Each of us needs to be touched by the pain of the world, and each of us needs to be empathic and prepared to help when the inevitable tragedy occurs. Ironically, though I have been able to come to a more realistic appraisal of the world, I would give all of this wisdom back in a second, to have my wife and city back. Yet, this return is not possible, so I can only hope to use this increased realism to help alleviate present and future suffering in disasters.

Coping through the transcendent. In addition to the important role that social support plays in healing grief, another important way of coping with trauma is a personal identification with something much greater than yourself (Greenberg, Koole, &

Pyszczynski, 2004). For me this has meant rededicating myself to helping vulnerable people in emergencies, including disasters and life-shortening illnesses. I hope to help the vulnerable primarily through research, education, and service in disaster social work. I am lucky to have meaningful and transcendent goals to work toward.

New Orleans, with its unique cultural traditions, is at high risk for losing these traditions at a time in which they are needed to comfort the grieving. Many vibrant traditions in the region had sustained people spiritually. These included traditions of music, the Mardi Gras Indians, the social aid and pleasure clubs, and the African-American mutual aid societies. All of these traditions have given meaning and hopefulness to the lives of people who too often had little access to less expressive forms of wealth. If these and other traditions die, what will remain to provide meaning to lives which have been so damaged? What larger and transcendent traditions will remain beyond the lifespan of its participants? Along with others (e.g. Gaines, 2006), I am frankly afraid that these great traditions will not survive Katrina.

Practice and Policy Implications

Here I offer several suggestions, based on personal experience of a national tragedy and framed by years of disaster research, education, and service. First, social work leaders, as well as leaders from other human services, should be an integral part of disaster preparedness, planning, and response. Though the immediate aftermath of a disaster may show altruism at its high point, altruism can rapidly degenerate into competition among organizations for visibility, among survivors for resources, and conflict between survivors and disaster aid agencies. The social work emphasis on social justice can insure that resources such as evacuation assistance are distributed to all vulnerable populations in areas at-risk for disaster. Social workers have the expertise to understand which populations are most vulnerable to disaster, and what services each of these vulnerable populations will need to survive and, hopefully, thrive after disaster (Zakour & Harrell, 2003).

With their knowledge of vulnerable populations and communities, the participation of social work and social service leaders in disaster preparedness can improve coordination of care for the most vulnerable. These vulnerable populations include low-income and older people, people of color, and those chronically facing the challenges of severe health or mental health problems. Each of these populations will require additional help and services to survive a disaster, and these are the historical clients of the social work profession. With the conceptual expertise of social workers in providing resources for recovery of vulnerable populations, the flow of resources and needed services to the most needy populations can be facilitated (Zakour, 2000). Without the participation of social workers in the preparedness, planning, and response stages of disasters, the most vulnerable populations will receive the least disaster aid, and this aid will not be timely.

Second, social work interventions should be rapidly provided after disaster to help repair the social support networks of everyone in the disaster community, with a particular focus on those who have lost loved ones. As was seen in Hurricane Katrina, the social networks of survivors were torn apart by evacuation and destruction of neighborhoods and communities. Through haphazard busing of family and neighbors to different parts of the country, low-income and African-American families were torn apart. Others who did not lose their jobs were often forced to relocate to different states to retain their employment. For months, many people did not know the location or condition of close family members and friends. Those vulnerable populations who lost the most, including low-income people and people already facing serious illness, were isolated at a time when social support was critical for emotional and even physical survival. An important aspect of essential social support has been the ability of survivors to talk to others about the death of loved ones (Gist & Lubin, 1989). In Katrina, even when other survivors were available for telling their own story, everyone was caught up in their own losses. Because evacuees were relocated for months to distant households and communities, the

disaster community in Katrina was not confined to New Orleans, the Gulf Coast, or even Louisiana and Mississippi. The challenge for the social work profession is to lead a coordinated effort to provide disaster services to survivors and their families throughout the entire country. This is a very different view of the disaster community as a far-flung network rather than geographically contained, as is usually assumed.

Finally, social work professionals need to be prepared to help survivors cope, particularly those survivors who have experienced the death of a loved one. Social work support and intervention in disasters are particularly needed because the social networks, families, neighborhoods, faith communities, and larger communities of survivors are incapacitated through physical destruction or permanent dislocation. If survivors do not receive timely assistance in recovery, many will be unable to cope with great loss and may suffer from long-term post-traumatic stress or PTSD (Kreuger & Stretch, 2003). Part of coping is to regain meaning and find meaningful activities in the context of a world that may no longer seem to make sense. Contrary to a deficit approach to social problems, many survivors can eventually experience psychosocial and spiritual growth after an extreme traumatic event such as disaster. Acquiring new meaning after catastrophic losses can be facilitated through supportive therapies, cognitive restructuring, and learned optimism. Learned optimism is a cognitive-behavioral approach in which individuals learn to increase their optimism through changing their attributional style. In an optimistic attributional style, positive events are interpreted as under the individual's control, as pervasive in effect and as more permanent in nature. Conversely, negative events in a person's life are viewed as temporary and of limited import, and caused by external circumstances and not by the individual's characteristics (Seligman, 2006).

Social workers might encourage survivors to eventually assume new roles that build on the personal strengths of survivors and are valued by their social networks, communities, and the larger society. Survivors can more adequately recover through meaningful

relationships and activities. One possible new role is that of a volunteer who provides emotional support for disaster survivors. Though the volunteer role should not be assumed too soon after a loss, many bereaved individuals find such a role to be meaningful one or more years post disaster (Barton, 1969). Culturally prescribed roles and standards for acting, when achieved, can provide "...self-esteem and the conviction that one is indeed of value in a meaningful world" (Salzman & Halloran, 2004, p. 232). Through these standards of being and acting, survivors who have lost loved ones are able to closely identify with something greater than themselves or even transcendent, such as a culture, nation, or spiritual tradition. The support of social work helpers can enhance post-traumatic growth and reduce the possibility of long-term psychosocial problems for survivors.

Conclusions

The situation in New Orleans has been one of immense suffering and loss, loss that I have observed and experienced personally. Although I knew that "The Big One" could occur anywhere along the Gulf Coast, before Katrina I was unable to anticipate the level of destruction and loss such a storm could cause. I am gratified that I am not only standing but moving forward; there are thousands of others who have had more loss and suffering than I have. Such loss is hard for me to fully imagine. For many, the traditional New Orleans that people relied on for comfort and meaning is gone and probably cannot be recovered. Massive recovery efforts which intervene at the health, social, and psychological levels will be needed for many years to come. Social work, with its generalist focus that spans clinical, community, and policy practice, is ideally suited to intervene in disasters, which affect societal well-being at many levels (Solomon, 1996). I hope that social work can take the lead in providing timely help for those who have lost so much, and lead the world and nation to be better prepared for comparable disasters in the future.

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Michael J. Zakour, Ph.D., is the Director of the Doctoral Program at the Tulane University School of Social Work. Comments regarding this article can be sent to: mzakour@tulane.edu.



Evacuees inside the Superdome.

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