Reconsidering the Role of a Disaster Psychiatrist

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The November 5, 2009, shootings at Fort Hood shook the nation, but I had a visceral response for different, personal reasons. I found myself unwilling to read the newspaper coverage and had the uncharitable thought that even if I was asked to help, I would not travel to Fort Hood to work with the survivors—a surprising response because I've established a career as a disaster psychiatrist. When the September 11th attacks occurred in 2001, I snapped into action, convinced that I had something to offer as a psychiatrist. But eight years later, armed with experience from responding to many disasters, I flinched at the thought of going to Fort Hood.

On the surface it is perplexing why I was so sure of what I had to offer back when I knew so little and why I felt that I had so little to offer now that I knew so much more. But on some level my strong negative reaction to offering my services at Fort Hood evolved from a series of personal experiences that began with the September 11 attacks.

In 1998, while I was still in residency, three colleagues and I started Disaster Psychiatry Outreach, a nonprofit organization dedicated to providing psychiatric services in the wake of disasters. By September 11, 2001, we had become attending physicians, and we were asked by the City of New York to organize the psychiatric services at the Family Assistance Center, a center that eventually became a single point of entry to a broad variety of services for families affected by the attacks on the World Trade Center.

In the first few days after the attacks, a flood of families came to the center simply to learn whether their relative was known to be in a hospital or was confirmed to be dead. A line of families stretched around the block waiting to discover the fates of their missing loved ones. We had obtained long lists of September 11 patients from hospitals throughout the region and a relatively short list of people who were confirmed dead. However, with the remains of the World Trade Center still burning, it quickly became clear that if a missing person was not on the list of those confirmed to be in a hospital there was virtually no chance that he or she was still alive. I quickly volunteered myself and my psychiatrists to do the tough job of checking the lists and informing families. As a newly minted attending physician, I was still getting used to the power of psychiatry. I reasoned that as an intern, during my internal medicine rotations, I had to notify families when patients died, and later, on my psychiatry rotations, I learned how to tolerate the intense emotions that can rush out when someone is given the time and tacit permission to open up. Therefore, I reasoned, psychiatrists were uniquely qualified to do this difficult work of giving life-or-death news.

I immediately realized that the task was harder than I thought. I was often at a loss for words, alternating between saying nothing and saying too much, sounding trite or "too shrinky." Without a way for me to engage them, the families simply walked away after I gave them the news that their relative was on neither list. They were eager to move on to someone who might have more information. Most showed no reaction at all, and the remaining families seemed annoyed. The clergy were better at knowing what to say, and families instinctively knew this and would open up with them.

Still, when a set of residents whom I supervised at my hospital came to the center to volunteer, I oriented them and entrusted them to take over this task. The long line of families waiting outside seemed to emphasize the urgency of having as many psychiatrists on hand as possible. On the basis of my own reactions, I told them, "Our professional training doesn't make us resistant to sadness or anger. All it does is teaches us to monitor our reactions to these emotions." I tried to reassure my trainees that I didn't care whether they stopped volunteering after speaking to one family or whether they stayed for a full eight-hour shift. They were eager to prove that they could be helpful. I challenged them by saying that the only thing that would demonstrate their professional skills would be if they could figure out when they were beginning to become overwhelmed and to come ask for relief before they burned out. Looking back, I realize that I was trying to warn them not to make a mistake that I had already made.

Less than an hour after they had begun meeting with families at the center, one of the residents came back to me, saying that he couldn't do any more. He told me about a woman who was informed that her husband was not on the hospital list. She proceeded to explain her detailed hypothesis that there was a large group of survivors who were still alive far below the surface of the World Trade

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Center ruins. She didn't seem to consider that such a space would surely have been crushed by the momentum of many tons of steel from the crashing towers and would have been uninhabitable because of the fires that were hot enough to melt the steel support beams, and even if such a space was somehow spared, it was very unlikely that it would still be supplied with oxygen after four days of fires. My resident admitted that he wanted to shake her and tell her that her husband was dead. I could feel his anger as he said this and was tempted to point it out. I realized that doing so would be as pointless as his urge to shake the woman. While I was still struggling for the right things to say to this generally stoic and guarded trainee, he started to cry. This made me tear up. I realized that staying silent and crying together was the right thing to do, so I stopped trying to be his supervisor and instead tried to bear witness to this shared moment. We left a little wiser about the limits of what we had to offer.

This moment modulated my optimism about the utility of my professional skills in disasters, but I still assumed that I would be perceived at least as a reassuring, nonthreatening presence. Perhaps I was not as great a source of healing as I thought, but surely I could not be mistaken for a source of harm.

Unfortunately, the September 11 attacks changed my relationship with many patients who suddenly saw my brown skin and foreign name in a much different light. Returning to my regular job of inpatient psychiatry, I encountered a psychotic woman who was involuntarily hospitalized and who began screaming that I was a "terrorist" and that I was "hijacking" her life. Although this was far from the first time that I experienced hostility or had become the focus of a patient's paranoid thoughts, her choice of words rattled me. I noticed that more patients asked about my ethnicity and religion than ever before. I quickly realized that many Americans did not understand the difference between Hindus and Muslims or between Indians and Arabs. Like so many others, I found myself stopped in unexpected places by young men in uniforms who were carrying guns and looking quite wary. Once, I was stopped on the way into the Midtown Tunnel in New York City on my way to visit my childhood home. Another time I was waylaid by airport security who questioned me long enough that I missed my plane. Looking back, I saw that some of these incidents were clearly racial profiling and others fell into a gray zone. Was I projecting? Or were others projecting their anger at the attacks onto me? In such circumstances, I would savor the irony that people were worried that I may be one of the terrorists when in fact I was working to heal some of the terror that had been inflicted. I now realize that I'd assumed that anyone who knew I was a disaster psychiatrist would understand that I was "one of the good guys"—despite my foreignness.

The recent attacks on Fort Hood challenged that smug assumption. This tragedy was committed by a psychiatrist. Moreover, it was committed by a psychiatrist who specialized in responding to disasters. Further, it was committed by a disaster psychiatrist with brown skin and a foreign-sounding name. In short, it was committed by someone who was too much like me for comfort. The September 11 attacks taught me that psychiatrists are not immune to trauma but we have skills that at least may allow us to help others. It also taught me that we are a much more limited force for good than we may want to believe. Fort Hood reminded me of a much more disturbing lesson: psychiatrists can be perceived as threatening, and in some rare circumstances they may really be threatening. It is difficult to hold onto such truths and still believe in yourself and in your profession enough to offer your services at a disaster. If one focuses too intensely on all of this, it could stop one from practicing disaster psychiatry altogether.

Fortunately, I am reminded of one final lesson from the September 11 attacks that has helped me step back from despair. After September 11, as with many other traumas, there was a collective tendency to think in black-and-white terms. There was much talk in the media of "evil-doers," and I began to understand this as a kind of collective regression to the primitive thinking we all have as children. I saw many of the people directly affected by the attacks responding in raw ways that made sense then but that now seem overly simplistic.

Such black-and-white thinking can motivate us to great acts of heroism as we try to prove to ourselves that we are "the good guys," but it can also prevent us from seeing the subtle and complex world we live in. Perhaps remaining realistic about the limits of my professional capacities is a way of resisting the pull toward oversimplification. Far from making me give up disaster psychiatry, this realization may actually make me a better disaster psychiatrist.