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Life at the Pile

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Luckily for me, I was not at the World Trade Center. I was not in the vicinity of the Twin Towers. I was not even in New York City, although I was scheduled to be later in the afternoon on September 11. There are many ironies about that day. Many people who lived through it have said, "But for... I would have been in the Trade Center." One of the most public of these "but for's" was the CEO who would have been with the 658 who died in his firm on the 101st and 103rd through 105th floors of Tower 1 but for the fact that he had brought his son to kindergarten. With relief and thankfulness, various individuals have related their stories to me. In providing disaster mental health outreach services to the personnel of the Port Authority of New York and New Jersey in the days and months after that day, I listened to many reasons why, by chance, each person was not at the World Trade Center that fateful day: "I would have been there if I didn't recently transfer... if I were not out sick... if my weekly meeting at the Trade Center hadn't been canceled," and so on. Although my irony on 9/11 was a matter of chance, it was not a matter of life and death. Nevertheless, it triggered my thoughts about the relationship between "chance events" and being dead or alive. Ironically, when I was a volunteer firefighter I almost died. On October 15, 1967, by chance, I was at a bowling alley fire that killed five firefighters. Ironies, "but for's," chance meetings, and matters of chance occur all the time. When they happen in relation to surviving a disaster, they become an indelible part of our memory. Disasters might traumatize us and shatter our beliefs. Nevertheless, how each of us appraises these happenings when they occur in association with a disaster gives meaning to a horrible experience.

What does this have to do with being a disaster psychiatrist? A disaster psychiatrist may also be a victim of disaster, either by direct exposure or by attending to those who were directly traumatized. Vicarious traumatization [1] and compassion fatigue [2] are terms that refer to the negative impact on professional caregivers as they listen to the trauma of others. This is the risk of being empathic and compassionate. This "secondary traumatization" may be so severe that it destroys meaning and purpose for the disaster psychiatrist, leaving him or her with nothing but doubt. Therefore, why expose oneself to this risk? I believe that psychiatrists should be self-aware so that they may not only better understand and care for those who are traumatized, but also protect their own mental health. Two questions disaster psychiatrists should answer for themselves are: What are the personality traits that are necessary to be a disaster psychiatrist? What are the reasons that I do or would do this work? In addition, novice disaster psychiatrists need to consider what they might experience while doing this work.

This essay has a threefold purpose. First, it shows how disaster psychiatrists should be self-reflective to give attention to meaning, empathy, and self-care and to answer the questions that I have posed. Second, it demonstrates that disasters dramatically confront us with matters of chance and the significance of human connections and attachment in the face of death. Third, it supports my belief that the devastation and death caused by disaster affirms life. I illustrate these three points by describing some of my experiences as a disaster psychiatrist, as well as relating my close encounter with death as a volunteer firefighter. By disclosing my experiences and

[1] First discussed by McCann and Pearlman (1990).
[2] Concept introduced by Figley (1994).

feelings, I hope that the lay reader will better understand those who do this work and that the professional reader will benefit by my example of self-reflection. In addition, I hope this essay will encourage those psychiatrists who have the potential for this work to join the ranks of disaster psychiatrists.

When I woke on the morning of September 11, I immediately thought about the lecture I would be presenting to the medical students at the College of Physicians and Surgeons in Manhattan. After breakfast I did some preparation for another project that was due the following week. While I gathered up my slides and notes for my lecture, I heard the news blaring from the radio. “An unidentified plane has crashed into the north tower of the World Trade Center." I wondered, “How could this happen? It's a clear day! “I further thought, "When the military B25 crashed into the Empire State Building in 1945, there was a very soupy fog. The pilot had lost his bearings and apparently mistook crossing one river for the other-maybe the East River for the Hudson." Being a disaster psychiatrist, I often think in terms of disasters --- historical ones and hypothetical ones. Immediately, I called out to my wife and daughter, “A plane crashed into the World Trade Center!" I checked my Breaking News Network (BNN) pager. I needed some confirmation from another source that this had really happened. Usually, this occurs in the reverse order. First my BNN pager buzzes with a report of the latest fire, serious motor vehicle accident, shooting, "jumper up" (the emergency radio lingo for a person about to attempt suicide by jumping), stabbing, and so on -- that is, the ordinary "garden variety" violence, mayhem, accidents, and crises. Then, depending on the newsworthiness of the event, it may or may not be broadcast to the public by TV and radio stations and, the next day, described in the newspaper. Even on a slow news day, a BNN reported event may take time to find its way to the attention of the general public or may never be reported.

A psychiatrist need not be a specialist in disaster psychiatry to provide care for the individuals who experience these "quiet" traumatic events. Psychiatrists treat the survivors of such events in hospital emergency rooms or their offices when these individuals develop mental disorders. Disaster psychiatry adds an outreach dimension consisting of screening for those at risk and providing very early interventions. This may involve rendering care in the midst of chaos at the disaster scene or at a nearby location, for example, an evacuation center. Why do this? Why extend oneself in this way?

Although most trauma and tragedy never come to the public's attention, our protectors -- emergency medical technicians, firefighters, paramedics, police -- are regularly exposed to the extremes of human suffering. Those who work in disaster mental health and many in emergency services and law enforcement acknowledge that our protectors need to be protected and supported for the sake of their psychological well-being. This was not always the prevailing view. When I was a volunteer firefighter no one paid any attention to the emotions of emergency personnel. If a critical incident such as a line-of-duty death occurred, no one really spoke about it. When our company returned to quarters from any fire, whether it involved a critical incident or not, our members assembled at the bar in the firehouse lounge to smoke, drink, and watch sports on TV. A significant development over the last 20 years has been the recognition that it is essential to care for the emergency responders. More recently, the pendulum has swung to the opposite extreme of individuals rushing in to perform mandatory group psychological debriefings. What had begun as a support for emergency workers has become a method applied indiscriminately to everyone for any kind of traumatic event. Now we are debating whether to debrief or not. Some research data demonstrates that psychological debriefing may be harmful for those who are highly distressed in the aftermath of a disaster. In May 2001, the New Jersey Psychiatric Association and the Department of Psychiatry of the New Jersey Medical School at the University of Medicine and Dentistry of New Jersey sponsored a full-day symposium on this debate. In the presentations and during the panel discussion, the consensus of the faculty was not

to "throw the baby out with the bath water" but to concede that there are problems with and limitations to psychological debriefing. Based on my experience as a volunteer firefighter and work as a disaster psychiatrist, I agree with this conclusion. On one hand, if a crisis counselor conveys the expectation that an emergency responder will likely develop complications after exposure to a critical incident, the responder may more likely develop a debilitating reaction. On the other hand, I would loathe a return to the days of not acknowledging the detrimental impact of traumatic events on emergency workers. To "first do no harm," we need to employ evidence-based interventions. Aggressively jumping in and administrating interventions may interfere with the normal process of coping with a traumatic experience. Nevertheless, it would be inhumane to suspend all interventions while further research is undertaken. Common sense dictates that we should be present, bear witness, and be emotionally supportive. These are basic aspects of the work of disaster psychiatrists.

Although media organizations contract for the BNN service, I sometimes wonder, why do I! I think that it is necessary for the work that I do. The mission of the Fort Lee Office of Emergency Management (OEM) Crisis Response Team, which comprises mental health professionals, clergy, and peer counselors, is to respond and provide mental health services at the time of a crisis or disaster. We voluntarily serve the citizens and support emergency personnel in Fort Lee, New Jersey. In addition, we deploy to other locations when requested to assist other municipalities -- that is, to provide mutual aid. Therefore, as chief of this team, I need to be aware of any emergency that happens in my locale. But I know this is an intellectualization. It may be my way of maintaining a sense of control. To know is to control. Therefore, if I know about the disasters and dangers around me, I feel more secure. These events do not "come out of left field" and surprise me. These events are not shocks; they are ordinary.

But it is obviously an illusion to believe that one can control the uncontrollable. In addition, Murphy's law -- what can go wrong will go wrong -- often prevails, and some say Murphy was an optimist. For example, even with my BNN pager, I almost missed the general alarm blaze in Edgewater, New Jersey; on August 30, 2000. While almost the entire west side of Manhattan was able to see the flames light the sky above the Hudson River, I was home on vacation and I let my BNN pager's battery run down. Fortuitously, I was watching TV when a breaking news caption started to march across the bottom of the screen: "NBC News reports that a fire is burning out of control in the Hudson River community of Edgewater, New Jersey. Stay tuned for the 11 o'clock news for further details." As the Channel 4 News helicopter transmitted live video that showed flames shooting 100 feet into the sky, I was out the door. After passing through the staging area where fire and EMS personnel and equipment from almost every municipality in Bergen County were preparing for action, I arrived at the fire scene. The fire had jumped across a street from its origin in a 400 unit townhouse complex under construction and blew out the windows of a 24-unit garden apartment, demolished nine private homes, destroyed utility lines and poles, and incinerated numerous cars. A fire engine from Edgewater that was among the first to arrive was caught in the heat as the fire leaped over what should have been a natural firebreak. The engine company crew had to pull back quickly as the soaring temperature melted the lenses of the engine's head and emergency lights and cracked its windshield. Although I am the chief of the Fort Lee OEM Crisis Response Team, at this fire I jockeyed ice water along with another OEM volunteer to the exhausted and dehydrated firefighters. Pitching in and performing simple tasks like this is an excellent way for a disaster psychiatrist on the scene to relate to the emergency personnel. While I provided them with water, I chatted and checked how they were doing. Similarly, disaster psychiatrists might hand out food and set up cots in a shelter. While taking care of the basic needs of the survivors, disaster psychiatrists are also attending to their psychological needs and well-being. In addition, when disaster psychiatrists pitch in to do these tasks, they are being team players at a time when teamwork is essential. A disaster psychiatrist needs to have the willingness to pitch in and the capacity for teamwork. Finally, although one

does not do these tasks for self-gratification, performing such tasks may be very gratifying for the disaster psychiatrist because this might be the only useful action to take at a particular time.

The day after the fire, as an American Red Cross volunteer at the victim reception center temporarily set up at the Edgewater recreation building, I provided mental health disaster services for some of the 67 people who had lost their homes. Here, too, there were quirks of fate. Unlike the "but for's" of 9/11, these intensified the trauma and loss rather than providing a sense of relief in escaping death. For example, one of the homeowners had just completed an extensive home renovation. Another had just finished restoring a classic car. Like lightning striking a place twice, a woman tearfully described how a short in a power transformer two years before had caused a blowout of all the appliances in her apartment just as this fire had once again damaged all of her appliances by causing an electrical surge in the circuitry of her apartment building. Nevertheless, there was also good fortune. It was life-sparing that this fire broke out in the early evening instead of later when these families would have been asleep.

My use of a BNN pager may merely be a manifestation of my voyeurism. Dr. Gidro-Frank, a psychiatrist distinguished in the annals of the New York State Psychiatric Institute, taught me that there are three traits essential for being a psychiatrist --voyeurism, paranoia, and narcissism. It was his dramatic way of saying that a psychiatrist needs sufficient curiosity to pursue a patient's story despite its being depressing, disturbing, or horrible; sufficient suspicion to doggedly investigate the source or sources of a patient's malady; and sufficient self-esteem to enjoy one's treatment successes and tolerate the failures. Some would also add the trait of masochism to this profile. The psychiatrist has to be a sufficient glutton for pain and suffering to listen repeatedly to horrific tales of human misery. These traits also serve the disaster psychiatrist very well. It is not only altruism that motivates disaster workers, including psychiatrists, to respond to a scene of destruction. We need to see for ourselves and be part of the action. Given the inherent danger, the drive to be there must be strong enough to override our instinct for self-preservation. But here is where paranoia may be life-preserving. By being suspicious and hypervigilant, psychiatrists might be able to sense danger and thus be protective of themselves and provide safety and security for those they are caring for in the aftermath of a disaster.

Voyeurism and paranoia, curiosity and suspicion, drove me on that Tuesday morning of September 11. What happened? Why did it happen? I was not satisfied just hearing about this news; I needed to also see it. Unknown to me then, I also would be driven to smell and feel it. I turned the TV on. Smoke was drifting from Tower 1. The anchorperson calmly and professionally reported what was known, which was not much. No activity was depicted. It reminded me of a "sleeper"-- a fire that doesn't show much on the outside but is furiously raging inside. Witnessing a sleeper is like seeing only the tip of the iceberg. Activity outside the fire building is moving gradually and in an orderly manner while beneath the surface, inside the structure, a variety of factors are rapidly brewing to erupt into total chaos and catastrophe. I thought, "The bowling alley fire was a sleeper." I stopped watching the TV, ostensibly to continue getting ready for the day. On reflection later; I realized that I stopped watching because that was not the time for me to be distracted by memories of the tragic fire that occurred in 1967.

My daughter, however, continued to watch the broadcast, saw the second plane fly into Tower 2 and yelled, “A second plane just crashed into the other tower!" Simultaneously, the three of us -- my wife, daughter, and I -- concluded that it had to be a terrorist attack. Our surprise changed to shock. I exclaimed, "All the bridges and tunnels will be closed. They'll close down the city." I confess that my next thought -- "How will I get to Columbia to give my lecture?" -- was narrow-minded and selfish. It is natural, however, for one, even a disaster psychiatrist, to have thoughts that are self-centered even as others might be suffering. The irony, which began my thinking on

9/11 about matters of chance, was that my lecture, which would not be presented that day, was titled "Traumatic Stress: Respect, Recognition, and Prevention."

Although I calmly drove to Englewood Hospital and Medical Center and saw my patients on the in-patient unit, I was suddenly caught up in the response to the terrorist attacks. Our hospital command post was already in full operation, thanks to the expertise and dedicated work of Steve Gaunt, director of safety. I was called to the command post and directed to open a crisis counseling center for the staff. I propelled myself into a whirlwind of activity. Crisis counseling was necessary; some of the hospital staff had difficulty functioning because they had friends and relatives at the World Trade Center. We used the PIE method -- proximity, immediacy, expectancy -- that was first used in World War I for combatants suffering with shell shock. We immediately provided crisis intervention near to where staff members worked with the expectation that they would return to their tasks. This "immediately getting back on the horse" approach was beneficial for our staff. It was also advantageous for our patients because it allowed Englewood Hospital to continue its efficient operation during this state of emergency. We also set up a family assistance center to receive the families and significant others of the hundreds of casualties we were told would be coming, but never did.

Leaving what I had set up in good hands, I rushed to my office to call my patients scheduled for the day to inquire how they were doing and to make alternate appointments. Next, the Fort Lee Office of Emergency Management paged me. I responded to Fort Lee High School and organized the response of 13 crisis counselors. The Fort Lee Emergency Medical Service (EMS) in collaboration with our Fort Lee OEM coordinator and my buddy Joe Licata, and MICCOM (Mobile Intensive Care Communications) for Northern New Jersey, established a huge medical triage and hazardous material decontamination operation on the high school athletic field. Approximately 40 ambulances and crews were standing by, along with four paramedic units. The emergency medical service incident commander of this operation was told to expect nearly a thousand people needing emergency medical care to cross to New Jersey via the George Washington Bridge. After all, many injured evacuees were being transported via a flotilla of ferries to Jersey City, directly across the Hudson River from the World Trade Center.

In Fort Lee, however, no patients arrived. Therefore, like other emergency personnel, disaster psychiatrists need to cope with "hurrying up and waiting" and the frustration of not feeling useful because there is no one that requires their help. Instead, on the evening of 9/11 there was an eerie scene of dazed people, silhouetted by the light from the streetlights and stores, walking in slow motion and milling around on the sidewalks near the George Washington Bridge. Commuters returning from New York City were desperately trying to get home. They did not spend time at the Fort Lee OEM reception center and shelter that had been opened for the public. This would have been only a brief respite after their walk up most of the length of Manhattan and across the bridge. Instead, they wandered aimlessly about, many with cell phones to their ears trying to make contact with their loved ones. Others queued at public telephones and waited their turn to call home. This was an impressive scene of survivors seeking to connect to someone with whom they had an attachment.

The next day, the need for mental health support escalated. I spent the rest of the week directing and providing disaster mental health services, and receiving telephone calls as the chairperson of the New Jersey Psychiatric Association Disaster Preparedness Committee in addition to caring for my patients. The numbness and detachment of the first 24 hours had worn off. People flipped into excitation. I worked with Port Authority police officers assigned to the George Washington Bridge command including those who were at the World Trade Center when the towers collapsed, employees of the Port Authority, and broadcast journalists and other staff at CNBC

and MSNBC. Everyone was in a state of hyperarousal. My colleagues and I worked hard to restore calm, order, and a sense of safety.

On Saturday I crashed. I hit the marathoner's wall, only I was not running a marathon or was I! Surely I was not among the terrified who had run from the collapsing Twin Towers. But I was among the many who were confronted with being vulnerable to another terrorist attack. I dealt with all of this by mobilizing. Now I had nothing to do. By slowing down I was able to feel. I felt sad, irritable, anxious, and angry. I railed at the terrorists.

For no apparent reason, the Port Authority did not accept my offer to have the Fort Lee OEM Crisis Response Team continue to work through the weekend. Maybe it was for the best because I could turn my attention back to everyday concerns. I had to complete my lecture on "Posttraumatic, Stress Disorder: The Role of Serotonin-Psychobiology and Treatment" that was scheduled for Thursday, September 20. I tried to work on it, but I could not concentrate. I was experiencing an emotional letdown. I became angry with my wife. It is difficult to return to the ordinary after a disaster. I had worked intensely with dedicated mental health professionals and clergy under very trying conditions. We were a great team, and I missed them. I did not want to let go of being part of the aftermath of 9/11. There is a scheme that describes the sequential psychological and biological reactions of the disaster worker. Its phases are alarm, mobilization, action, and letdown. I was in the midst of the letdown phase -- that is, the transition from emergency mode to normal work routine and usual life. I was not satisfied: with only hearing about it and seeing it on TV. I needed to go to Ground Zero to experience it firsthand. I had done a lot but I felt I needed to do more. I had to do something, anything. I could not be inactive. I could not tolerate being "on the bench" for the weekend. I yearned to get "back in the game." I called a number of contacts who could possibly get me access to Ground Zero but I had no luck. Then I called Diana Brown, my friend and colleague from the American Red Cross (ARC). We have worked together as ARC Disaster Mental Health volunteers. Seemingly, I called her to get to Ground Zero via the New York Chapter of the ARC. But it soon became apparent that I called her just to make a connection and talk to someone who was a disaster mental health veteran and would understand. I felt much better after I spoke with her, even though it did not get me to Ground Zero. As a disaster psychiatrist I have observed, over and over again, the powerful force of human attachment. While at fire scenes, I have witnessed individuals breaking through police barricades to find their loved ones. Even during the drills of our Fort Lee School System's Community Crisis Response Team, the parents did not require a script for their role-plays as they ad-libbed their urgent desire to be reunited with their children. On 9/11, I took a break from the bustle at Englewood Hospital to return home and hug my wife and daughter. The next day my daughter fielded heart-wrenching telephone calls at Englewood Hospital from individuals frantically seeking their relatives or friends. Facilitating the reunion of disaster survivors with their families and significant others is an essential task for the disaster psychiatrist. The intensity of this attachment extends to one's pets. This was evident at an occupied multiple dwelling house fire at which our Fort Lee OEM Crisis Response Team assisted. This fire occurred on Sunday, September 16 during a community memorial service in Fort Lee for 9/11. So I was back in action. We aided a boy and his family who feared for their two cats that were trapped inside the burning building. Fortunately, one was rescued.

When I finally got to Ground Zero as an observer with the Port Authority, it was not what I expected. I anticipated only death and devastation. Instead, it was like an anthill -- a colony of activity. Crews of steel and demolition workers, firefighters, police, and recovery teams swarmed over the area. Four-wheel "Gators"-- all-terrain transport units-scurried hither and yon. The movement of cranes, backhoes, and trucks, along with a multitude of human voices, created a cacophony. Trucks pulled in, were loaded with wreckage, and pulled out. Shanties circled the periphery on the southwest side. Ground Zero was an entire village filled with life. I felt safe and

protected because I was in the good hands of the Port Authority police officer assigned to me. I did not require a Ground Zero ID badge. Whenever a National Guardsman or police officer approached to check my ID, I just pointed to the officer at my side. Each time we were immediately ushered along until someone yelled at us, "Hey! Hey! This a hard-hat area!" A man dressed in coveralls, heavy boots, and a hard hat who appeared to be a foreman approached us. He signaled for one of the Gators to stop. He took two yellow hard hats from the cardboard box on back of this vehicle and handed one to each of us. As my escort turned to me, he said, "I forgot. Maybe we should've stopped at the Port Authority headquarters on the way in to pick up some gear." My protector had slipped up. It was unfair of me to have placed this responsibility on him. We stood weeping by the wall of remembrance, where there was an abundance of flowers, stuffed animals, and letters, in addition to photographs of the missing members of the New York and Port Authority police departments and the city's fire department. Perhaps because of his loss I should have been protecting him. We then made our way back to the other side of the pile.

"Joe! Joe!" I heard my name being called. It is amazing what flashes through a person's mind in a matter of seconds. There was no apparent source. Being a psychiatrist, I really did not want to admit that I was hallucinating. Because of the weirdness of my surroundings, my mind certainly could have perceived something that did not exist. I was unable to use the excuse that it was an illusion -- an actual sensory stimulus that my mind was distorting, like when the wind whistling in the leaves sounds like someone calling your name. There was dead silence at this location. Next, I saw someone running from the top of the pile. In a flash, he was next to me. He was clad in Ground Zero fashion de rigueur -- hard hat, khaki clothes, work boots, a necklace of official ID badges, and a particle filter mask dangling by its straps from his neck. With much relief for my sanity I knew who had been calling my name. It was Tony Ng, a psychiatrist and the medical director of Disaster Psychiatry Outreach. He was not only a life, but a life that I knew personally. Therefore, meeting Tony was not only an example of a human connection but represented the ultimate "proof" that there was "life at the pile."

It was life affirming as Tony and I made contact with a firm handshake. Statisticians assure us that meeting someone we know from back home while visiting a distant location is highly probable and not bizarre. Nevertheless, we are amazed when we have one of these "it's a small world" experiences. Certainly, it would be an even greater probability that I would encounter Tony at Ground Zero. We are both dedicated to the same work. Why wouldn't we both be drawn to this place? Yet it was a very odd experience. I did not anticipate that I would see him at Ground Zero. A corollary to this unexpectedly-running-into-someone-you-know phenomenon is meeting-someone-who-you-should-already-know-but-don't. Here at the pile, after I introduced my PAPD escort, Tony introduced me to Dr. Carlos Almeida. I should have already known him because he is the director of the Comprehensive Psychiatric Emergency Services at Columbia-Presbyterian Medical Center (CPMC), and I teach emergency psychiatry to the medical students assigned to that service. I suppose not meeting someone in my own backyard could be attributed to the fact that CPMC and the College of Physicians and Surgeons are large organizations but this encounter was an example of how we are connected in many un- known ways. Hence, I contemplated the variations of human connections and the strangeness of chance encounters.

There at Ground Zero Tony and I chatted. He told me about his work as the medical director of DPO in New York City. I filled him in about what I was doing in New Jersey in response to 9/11. Meanwhile, Carlos and my police officer engaged in a conversation. As if prompted by a square-dance caller, we swapped partners and our talking resumed. Finally, we formed a group of four and exchanged comments. Despite being surrounded by death and destruction, we were engaged in lively human interaction.

In addition to coping with witnessing the remains of the dead, disaster psychiatrists need to tolerate chaos and destruction. Veterans need to prepare rookie disaster psychiatrists for what they will face. During our mundane conversation amid the devastation, my mind pictured another pile -- the result of the bowling alley fire in 1967. Like this pile, the pile that I remembered consisted of building material detritus. Here and now, the wreckage was large, twisted beams of steel, pulverized concrete, and other destroyed construction materials; there and then, the rubble was broken cinder blocks, splintered wood, and plaster dust. Although not composed of the same inanimate materials, the difference between the two piles was mainly a matter of magnitude. Although the other pile was much smaller, it, too, was a burial mound. Here the count would approach 3,000, including 343 NYFD firefighters, 23 NYPD officers, and 37 PAPD officers. Under the debris of the other pile were the crushed, mangled bodies of five firefighters.

We bade farewell and continued to circle around to the north side. On our way we met a PAPD officer whom my officer knew well. They chatted. We continued on. By now I was beginning to taste Ground Zero. I could feel the dust in my throat. I wondered how the workers who were there day in and day out were able to survive. I began to question. Did I really want to be at Ground Zero? Isn't it too risky? Why do this work?

I also began to think how I happened to be at that fire in 1967. I was not supposed to be there. I should not have been out of my bed. The siren was clear and loud when its sound jolted me out of my slumber. It was a little after four o'clock in the morning. Still half asleep, I quickly got dressed. As I left my house, the cold air hitting my face fully awakened me. I drove to my firehouse. It was dark and the door was locked. Our siren was silent. No one else was responding. Could I have dreamt that I heard the siren? At that moment I heard a siren in the distance. The sound was coming from the neighboring town to the south. I was curious. I thought that since I was up anyway, I would check it out. I drove until I came on the fire scene. It was a sleeper. There was no visible fire. The movement of the firefighters seemed to be in slow motion. They were getting ready to attack the fire through the front door. I went around to the side of the building where an engine company from a neighboring town was working in an alley. I encountered the chief of my department. He was there even though none of our Fort Lee companies had been called out. I was present at a place where I should not have been, at least not yet. My chief and I talked as we stood adjacent to the hose crew who were about to make an entry through the door on the north side of the building. It was a 20-foot-high, 100- by 150-foot structure constructed of cinder-block walls with a bowed roof supported by trusses composed of huge wooden beams and struts. For some inexplicable reason the chief and I turned simultaneously and started to walk away. There was a thunderous boom. We reeled around. Without warning the entire structure collapsed and crashed down on the crew of five. Instantly, the chief radioed the dispatcher to call out my company. I heard my firehouse's siren wail. This would have been the alarm for me to heed. This would have been the time for me to start out.

Joining the flurry of activity by emergency personnel, I went into action and helped fight the fire. When the fire was extinguished, like the disaster survivors that I have since worked with after various disasters, I yearned to be with those I loved after this close call with death.

In conclusion, the serendipity that occurred in relation to the two piles separated by years but linked in meaning affirms the fragility and preciousness of life and the healing bond of human attachment. My experiences with disasters and the survivors of disaster confirm for me that exposure to trauma may be a positive life-defining experience. Although disasters harshly confront us with death and despair, they paradoxically affirm life and purpose. Nevertheless, because providing outreach for disaster survivors might be traumatizing for disaster psychiatrists, they should properly prepare. This preparation includes answering the following questions: What

might I experience? Do I have the necessary personality traits to do this work? What are my motives? I have shared some of my experiences as a model for answering these questions. Interwoven in the narrative of my experiences I have described some characteristics that I think are necessary for being a disaster psychiatrist. Obviously, each psychiatrist should determine his or her own motives for doing this work and the meaning of being a disaster psychiatrist. When I reflect on the bowling alley fire and remember my grief for my brother firefighters and their families and friends, I know why I am a disaster psychiatrist.

References

Figley, C. R. (1994), Compassion fatigue. Presented at: Premeeting Institute of the annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.

_____, ed. (1995), Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized. \New York: Brunner/Mazel.

McCann, I. L. & Pearlman, L. A. (1990), Vicarious traumatization: A contextual model for understanding the effects of trauma on helpers. J. Traumatic Stress, 3:131-149.