



Short Paper

The Role of Mental Health Providers in Crisis Intervention: The Case of September 11th in New York City

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WCPRR Oct 2008: 187-190 © 2008 WACP
ISSN: 1932-6270

INTRODUCTION As of 2007, six years will have passed since the attacks of September 11 in the US. This atrocity took away thousands of lives and left psychological imprints on many people around the world. In this short paper, I share my experience of September 11 as a clinical social worker in New York City. Until two years ago, I worked as a psychotherapist at an outpatient mental health clinic in Lower Manhattan. Most of my clients were Japanese speakers, but some spoke English during sessions either because they were native English speakers or because they prefer to relate to me in English. In the following, I will describe my work place, characterize the Japanese community in New York City, and then discuss September 11 and its lessons for crisis interventions in minority communities.

JAPANESE CLINIC AND THE JAPANESE COMMUNITY IN NEW YORK

The Japanese Clinic of Hamilton-Madison House opened its doors to the Japanese and Japanese American community in 1983 as part of a pilot program launched by New York City to serve its multicultural population. It is funded by New York State and New York City, fundraising activities, corporate and personal donations, and patients fees. Because it is the only publicly funded outpatient mental health clinic for Japanese on the East Coast of the United States, and because it offers relatively inexpensive bilingual services, the clinic experiences heavy demand throughout the year. The Japanese Clinic provides a wide array of psychiatric and psychological services. Clinical social workers are in charge of providing psychotherapy, and psychiatrists provide medication. Besides clinical work, Hamilton-Madison House also conducts community outreach activities such as giving talks on mental health and planning fundraising events. During the past twenty years, the clinic has established working alliances with other community resources, such as the Japanese Consulate of New York, religious organizations, schools and hospitals. After September 11, these organizations referred many victims of the attack to the Japanese Clinic.

The Japanese community that the clinic services differs from other immigrant communities in New York City. Rather than arriving at airports with dreams of American citizenship, most Japanese are

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Received August 31st, 2008. Accepted September 30th, 2008.

there temporarily for business or study, or at least that is their initial intention. Even those who marry Americans often retain Japanese citizenship and live in the US as a permanent resident. Japanese also do not bring the rest of the family to the US, nor leave their mother country behind. Rather, they are often supported by their families and businesses in Japan. Because of a stronger Japanese yen since the 80s and a safer New York, more middle class Japanese have arrived in New York for temporary stays.

In fact, New York has the largest number of Japanese citizens outside of Japan. According to the Ministry of Foreign Affairs, in 2004 roughly 60,000 Japanese nationals lived in the New York area. But when they stay longer, many of them begin to face problems because they do not seek to naturalize. Even if they learn to get used to daily life in New York, they never feel completely at home because they are not entitled to receive many of the public services, such as Medicaid and unemployment and welfare benefits, available to American citizens and permanent residents,.

The Japanese clinic serves this community. The clinic also works with Japanese Americans whose first language is English. About 80 % of clients were female, and the majority was in their late 20s to early 40s. The clinic offered to treat various mental illnesses and emotional difficulties, including schizophrenia, mood and anxiety disorders, alcoholism, domestic violence issues and child abuse cases, cultural adjustment issues, and marital problems.

HAMILTON-MADISON HOUSE I would also like to add a few words about Hamilton-Madison House, which housed the Japanese clinic. Hamilton-Madison House was founded in 1883 as a settlement house, helping new immigrants by providing social and educational services. Its mental health program is only a small fraction of the agency as a whole, and it offers services in many languages, including Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Japanese by bilingual and bicultural clinical social workers. This multicultural character of the agency later proved to be the most effective and significant asset the organization possessed in reaching out to September 11 victims. Another important point is that it was the closest social service agency to ground zero.

SEPTEMBER 11, 2001 AND ITS IMPACT ON THE JAPANESE COMMUNITY On the morning of September 11, as I came out of the subway station on my way to work, I saw the twin towers in flames. I had no idea what was happening, but thousands pieces of paper were flying out of the building like white butterflies, which for me marked the first of a series of surreal images of September 11. Soon after arriving at the clinic, I heard a bang and felt the building shake as the towers fell. From out of the window, I saw hundreds of people, escaping from ground zero covered with white dust, walking like zombies on the highway next to our building. Next, we were all evacuated and in the chaos walked home.

The clinic was closed for a few days as we were prohibited from entering below 14th street for security as well as rescue reasons. However, as soon as we opened, people walked in despite the fact that downtown was still in crisis and our phones were down. One patient, who escaped from the collapsing towers, was suffering from acute anxiety symptoms, including panic attacks, nightmares, insomnia, and flashbacks. More distressing was her sense of guilt. She could not forget the faces of firefighters who climbed up the stairs as she descended for safety. Her mother in Japan told her that she should not be frightened, but rather grateful for her survival. This added to her survivor's guilt and she felt ashamed of using resources, such as hospitals and ambulances, because she began to believe that people more severely hurt should be given priority.

Similarly, many New Yorkers started to feel guilty for not being able to help. The idea of death penetrated the minds of those in the city, and vulnerability of life became even more apparent. A sense of loss was also prevailing. Not only the loss of lives and buildings, but the loss of security,

consistency, continuity, innocence, life and hope. For a while, the whole city was buried in fear, confusion, and despair.

September 11 brought people together through this collective experience, but at the same time, how the event resonated in an individual's mind was deeply personal and intimate. One patient who was raised by an over-critical mother felt alienated, misunderstood, and very alone when her American boyfriend condemned the terrorists as Kamikaze pilots and compared the attacks to Pearl Harbor. She became withdrawn and depressed. Another patient behaved oblivious to September 11 and the changes in the city, insisting that it did not affect her as it did others. This was her usual response to any emotionally charged event in her life. Months later, when reflecting on her reaction to September 11, she shared that she was trying hard not to feel anything because she was afraid she would break down if she did. This insight enabled her to explore her childhood history of physical abuse by her mother. And yet for some, it awakened long forgotten traumas, such as the Kobe Earthquake or the Sarin subway attack in Tokyo. Another patient had great difficulty with the US government as it launched a preemptive war on Iraq. He spent many sessions verbalizing his anger, irritation, and sometimes helplessness toward the government for ignoring the opinion of others. As time passed, we learned that he had a self-absorbed domineering father whom he had not spoken to since he left Japan more than twenty years prior.

It is impossible to generalize the psychological experiences of Japanese patients in post 9-11 New York. The event affected people individually, and everyone coped differently. So, I would like to list a few things from a socioeconomic standpoint, rather than an intrapsychic one, that I found significant in providing crisis interventions to the Japanese community.

What distinguished September 11 was the continuous sense of danger it produced in New Yorkers. In the ensuing months, security alerts were repeatedly issued. Many were copy-cat bomb scares, but it was difficult to tell which ones were real. Many Japanese worked in midtown where there are many buildings regarded as terrorist targets, such as the United Nations and the Empire State buildings. With every new threat, buildings were evacuated and subways were stopped unannounced. Bridges and tunnels were provided with security checkpoints and police presence increased with machine guns and bomb sniffing dogs in every street corner. During the anthrax scare, we were instructed to seal off the windows and never open suspicious mail. Gas masks were sold at a high price, and doctors filled many prescriptions for antibiotics said to treat newly identified viruses. People talked about preparing for biological, chemical, as well as radioactive bombs, and we were thrown into an unforeseen future.

In this atmosphere, it became difficult for our clients to visit the clinic not only because it took longer to get there but also because they feared for their own safety. A sense of danger prevailed in the city. As soon as one alert ended, another would follow. The new alert would disrupt our lives and place the city under heavy surveillance again. This went on for months, and the situation became worse after the US invaded Afghanistan and the Iraq war began.

These repeated threats often triggered memories of September 11. They also fomented people's sense of fear, powerlessness, and helplessness. One client described it as riding an emotional roller coaster with no end in sight. As the situation prolonged, it created more difficulties for our already vulnerable population.

Secondly, September 11 brought about significant historical, economic, and political implications. Some patients faced relational difficulties with their American partners because they felt misunderstood or their political views started to diverge. As the US launched wars in the Middle East, patients who received a pacifist education in Japan voiced their sense of dislocation from American society. The polarizing political message of dividing the world into America and the rest of the world isolated foreigners living in New York. Americans started to emphasize patriotism. Some patients felt isolated from American society, as they lacked a political voice.

In addition, because of the economic recession following September 11, many Japanese patients lost their jobs. Many were unable to receive public benefits available to American counterparts because of their visa status.

Moreover, due to the tightening of national security and the raids on illegal immigrants, it became more difficult for Japanese students or temporary workers to renew their visas. Some clients experienced strain in their relationships with their families in Japan, which consciously or unconsciously was their reason for leaving Japan in the first place. For the first time, they were faced with an option of either returning to Japan or staying in the US undocumented. Immigration policies seemed to change every week and no one could forecast the future as the political climate changed constantly. At times, these newly emerging needs unique for the foreign population required more immediate attention than psychological treatment.

DISCUSSION In conclusion, first, interventions that incorporated long-term perspectives were essential after September 11 for psychiatrically and emotionally vulnerable populations, especially ones with history of trauma. Second, interventions should encompass perspectives of foreigners who face unexpected needs because of their limited resources and immigration status. Clinicians also should address meeting their immediate and concrete needs flexibly. Lastly, it was helpful to use media, such as local newspapers, community papers, and the Internet, in reaching out to potential clients because the New York Japanese community unlike Chinatown lacks a geographical boundary. The Japanese clinic actively sought media exposure after September 11 and provided psychoeducation on trauma. The clinic also created brochures explaining stress symptoms after a disaster and ways to treat them, and distributed them through the media. Because there was no Japan town, it was necessary to identify a main organization that could act as an emergency headquarters. The Japanese consulate of New York took leadership in organizing a committee that met on a regular basis, and developed a disaster plan. The consulate also relied on the Japanese clinic for its local resources, its links to US government agencies like FEMA, and its many years of experience in serving the New York Japanese community. It is apparent that community building that strengthens communication and cooperation among its resources and members should be a priority for handling large-scale emergencies.