RESEARCH PAPER

IMPACT OF TRAUMA ON SEPTEMBER 11, 2001

EMERGENCY PERSONNEL

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ABSTRACT

This research paper focuses on the impact of trauma on emergency workers of the September 11, 2001 terror attack in the United States. The first section gives an account of the prevalence of such trauma on various rescue personnel. The second section focuses on the manifestations of trauma among rescue personnel, while the last section gives an analogy of the remedy that was implemented to manage the trauma.

Key words: : trauma, emergency personnel

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INTRODUCTION

The concept of trauma is used to describe any situation or experience that is distressing and emotionally painful. Trauma can be either physical or mental. Physical trauma refers to the body's response to serious injury, while mental trauma refers to painful feelings and frightening thoughts. Trauma can be caused by intentional involvement in violence, witnessing violence, ensuing chaotic life condition, fear, and anxiety. These in turn cause long-term effects on health and other aspects of life among victims. Although trauma has been traditionally and theoretically viewed as a sickness or deficiency in moral character, the current theorists, psychological and medical practitioners perceive it as a common injury that requires healing. The emergency personnel that were involved in the rescue mission on September 11, 2001 experienced great trauma that negatively affected their well-being

PREVALENCE OF TRAUMA AMONG SEPTEMBER 11, 2001 EMERGENCY PERSONNEL

The terrorists' attack of the World Trade Center on September 11, 2001 is one of the most traumatizing events in the history of the United States. This did not only affect the survivors and witnesses, but also emergency personnel. The emergency personnel that were involved in this case included the Red Cross personnel, the police, media reporters, emergency doctors and nurses, fire fighters, counselors, social workers, and other volunteer organizations and individuals (Fullerton, Ursano, & Wang, 2004).

A demographic analysis of post-traumatic stress disorder reveals that prevalence varied from one occupation to another and also depended on the nature of the involvement. For instance, fire fighters were more susceptible to higher risk of trauma as opposed to minor constructions. As a result of that, disaster personnel who directly handled fire victims such as fire fighters, police, and emergency medical personnel were more affected than construction engineering and sanitation workers. As a result of this, un-affiliated volunteers and other government agencies that performed minor duties were reported to be less effected as compared to those who performed core duties (Fullerton, Ursano, & Wang, 2004).

The duration and time frame of involvement in emergency service was also reported as a determinant of the severity of the trauma. For instance, those who reported to the scene immediately and on the first day of occurrence were reported to be at higher risks of trauma than those who reported later. The risk also increased with the length of time that all personnel took to work at the scene. This is because those who reported immediately witnessed more traumatizing scenes than late reports who could have found most of the critical cases managed. On the other hand, those who worked for long hours also had longer exposure to these traumatizing events and hence were at a higher risk

(Silver, Holman, McIntosh, Poulin, & Gilrivas, 2002).

In addition to these, it was also observed that the prevalence of Post-Traumatic Stress Disorder (PTSD) varied according to the nature of specificity of the functions performed. For instance, emergency workers in occupations that were less prepared for such cases were more affected than others. Although such emergency workers as fire fighter, construction engineers, sanitation workers, and other volunteers were incorporated, managing terrors' attacks was not their core duty. They were thus exposed to a greater risk of PTSD (Silver et al., 2002). Furthermore, higher risks were reported for workers who worked outside their mainstream profession. For instance, medical personnel who engaged in fire fighting, as well as sanitation workers who engaged in search and rescue were more affected than others who strictly performed within their professions (Fullerton, Ursano, & Wang, 2004).

Prior training and preparedness were another factor determining the prevalence of PTSD in the World Trade Center disaster. This is based on the argument that prior training is likely to increase self-efficacy and internal locus of control. A successful application of training knowledge could therefore be useful in duty satisfaction, hence reducing the rate of trauma. For instance, research reports reveal that the police are likely to record lower prevalence of psychological distress than other risqué workers (Fullerton, Ursano, & Wang, 2004). This could have been experience based on the argument that police screening procedures are likely to lead to a selection of only resilient work force. Furthermore, many police officers are also likely to underreport psychological distress because of the fear that they might be perceived as irresponsible police who are not able to perform their duty. This is also influenced by the nature of work they do, which involves carrying firearms on a daily basis and sometimes even shooting (Rothbaum,

Meadows, & Resick, 2000).

An analysis of the emergency and rescue personnel of the World Trade Center attack also revealed that lack of access to mental health service was responsible for the increase of risks of trauma. For instance, it was generally assumed that some personnel, like the unaffiliated volunteers, sanitation workers, and construction engineers were not directly involved in handling most traumatizing cases. As a result of this, most of these personnel were not included in the injury and surveillance programs that were established in various health institutions in order to help with stabilizing and recovery of the traumatized workers. This made such groups of emergency personnel more vulnerable than others like police and fire fighters who had additional stress management services through other organizations (Silver et al., 2002).

Prevalence of PTSD was also determined by the casualties that resulted from the 9/11 attacks. For instance, the media reported that fire fighters lost in the disaster were six times more numerous than the police who were lost. These fire fighters therefore felt more traumatized after the event based on the loss of their colleagues and friends. This was also experienced by any emergency worker who lost any close relative or friend in the entire attack (Silver et al., 2002).

Lack of recognition has also been cited as a factor responsible for the increase of trauma and psychological distress. For instance, post-terror attack analysis revealed that certain groups of emergency workers such as constructionists and sanitation workers were not accorded equal recognition as others who participated in the same disaster. This therefore generated a feeling that their efforts were not appreciated, hence making them suffer from prolonged psychological distress (Silver et al., 2002).

EFFECTS OF TRAUMA ON SEPTEMBER 11, 2001 EMERGENCY PERSONNEL

In general, traumatic experiences such as physical attack, sexual assault, involvement in serious accident, terror attacks, and other serious accidents expose victims to psychological dangers and disorders. As a result of these, survivors and emergency workers are likely to have some emotional and psychological experiences that they have not had before. These traumatic experiences affect people in various ways and are manifested in various behaviors. It is also observed that the level of seriousness of these symptoms depends on a number of factors. These include the person's natural ability to cope with stress, experience before the trauma, and the severity of the trauma, as well as the kind of measures that a person takes to heal from the trauma (Rothbaum, Meadows, & Resick, 2000).

The terrorist attack on the World Trade Center that occurred on the 11th of September, 2001 affected emergency workers in various ways. For instance, most of them felt that the traumatizing experience was a result of their fault, especially if they could have had the capacity to prevent it before its occurrence. Others also had a feeling of weakness, especially if colleagues who had the same experience did not go through the same magnitude of trauma. As a result of this, some of them turned to the use of alcohol and other drugs in order to make them feel better and forget the scene. Others also turned away from family and friends who seemed not to understand them and could not cope with their experiences and behaviors (Silver et al., 2002). Lack of social support systems only served to increase the trauma to risky levels among those emergency workers who led solitary lifestyles.

Fear was one of the most immediate effects of trauma among emergency workers. After the exercise of saving lives and managing the disaster, many emergency personnel were reported to be uncomfortable, especially whenever the media aired the scenes of the attack. The pain of the experience could therefore be provoked, hence making them avoid the reminders (Silver et al., 2002).

Re-experiencing symptoms also manifested among the emergency personnel. These refer to experiences that a traumatized person goes through emotionally or mentally, which tend to remind them of the events during or immediately after the disaster. In this case, re-experiencing effects that were reported include mental replay of the occurrence, mental images of the event, and a repetition of the emotional feelings, which were agitated by the disaster (Rothbaum & Schwart, 2002). These experiences also caused a feeling of danger among emergency personnel. For instance, some were reported to be showing signs of panic sensations, extreme anger, and even desire to escape from their professions. Upset of memories of images and thoughts of the disaster were very common almost among all groups of the emergency workers (Rothbaum & Schwart, 2002).

Mental flashbacks and bad dreams were also witnessed among such people. These were also accompanied by getting upset whenever a reminder about the disaster was seen, heard, or felt. Dangers of pain, fear, and anxiety were also realized. These were further followed by feelings of extreme aggressiveness and need for self-defense even if there was no actual danger. All these re-experiencing symptoms occurred as a justification of the fact that their bodies and minds were still struggling to cope with the traumatizing disaster (Silver et al., 2002).

Emergency personnel are also very susceptible to avoidance symptoms

associated with the September 11, 2001 World Trade Center Disaster. Since many were aware that memory of the disaster may be upsetting, they opted to practice intentional avoidance of such talks as a way of quickening the healing process. These included avoiding talks, feelings, associations, and sensations that could invoke their memory about the 9/11 incident (Rothbaum & Schwart, 2002).

In other situations, emergency personnel reported long-term effects of the traumatic events of the terror attack. These included irritation, sleep disturbances, aggression, and over- vigilance. Irritability in this context refers to a situation when one experiences an excessive reaction to external and internal stimuli. Irritability further manifests in individuals by making them impatient and easily angered (Rothbaum & Schwart, 2002).

Aggression was also reported through the disposition and hostile behavior among the emergency personnel. During the rescue mission, many of these personnel employed a lot of force, which was not only physical, but also emotional and mental. As a result of this, a response to any act that tended to cause harm or social dominance attracted a similar use of force as the one exerted during the rescue missions. Although the attack may be dismal, the fear of a repetition of the trauma attracts similar reactions (Rothbaum & Schwart, 2002).

Hyper-vigilance was also witnessed, especially among the security agencies like the police. The personnel were propelled to maintain a high level of awareness and sensitivity of their surrounding environment. This caused frequent scanning of even constant workers within the buildings in order to avert any potential threat. Although extra-vigilance is encouraged among security agencies, extreme levels are perceived as abnormal and may even lead to paranoia. Those who

experienced this effect were abnormally aroused by sights, sounds, people, behaviors, or smell that seemed unique to their normal environment (Silver et al., 2002). Others also developed extreme fear of certain items, incidences, or situations in life. For instance, those who handled many corpses got scared due to scenes of dead people or funerals, imagining that such deaths would always remind them of the tragic disaster of 9/11 (Rothbaum & Schwart, 2002).

INTERVENTION STRATEGIES AGAINST 9/11 TRAUMA

All trauma treatment specialists agree that before an intervention is implemented in trauma cases, certain assessments have to be made. These include the interventions directed at direct victims of disaster or emergency personnel. This begins by conducting a full assessment of the situation of the individuals affected by the trauma (Lewis & Roberts, 2002). This is based on the observation that although many people can be exposed to a similar traumatizing situation, the nature and levels of impact can never be identical. Furthermore, trauma treatment specialists also believe that these people have to be reached as early as possible. Early treatment of trauma is perceived to be one of the ways of avoiding acute traumatic stress that may result into chronic stress disorder. In this assessing process, it is also significant to consider the level of emotional injury, responsiveness, shock, pain awareness, and other relevant influences that relate to the event (Rothbaum & Schwart, 2002).

After the September 11, 2001 attack of the World Trade Centre, several strategies were implemented to facilitate recovery and healing of both direct victims, as well as the rescue personnel of the disaster. American Academy of Experts in Traumatic Stress played a leading role in this course. This academy is made up of a network of interdisciplinary professionals who specialize in providing interventions and emergency responses to survivors and interveners of traumatic events (Silver et al., 2002).

In this process, the academy's systematic and practical intervention manual was recommended for use. This describes ten basic procedures that are implementable in providing guide posts for all trauma victims, whether emergency personnel or direct victims (Fullerton, Ursano, & Wang, 2004). Various counseling centers were established in the nearby medical facilities. The experts then began the entire process by assessing the danger or the safety of emergency workers who came for treatment. After this, the trauma experts considered every perceptual injury before evaluating the level of responsiveness. This then led them to effectively addressing each medical need by identifying and responding to each traumatic disorder (Fullerton, Ursano, & Wang, 2004).

The emergency personnel were also allowed to freely introduce themselves, state their professions and roles, especially where these could not be automatically identified. The trauma victims were also allowed to tell their own stories and experiences as the counselors gave them active listening as a way of developing rapport and establishing a friendly connection (Fullerton, Ursano, & Wang, 2004). At the end of each session, the clients were given normalizing and educative training, which intended to get them out of the past and describe the future. For cases that proved to be more complex, referrals were encouraged to

more expert personnel (Silver et al., 2002).

Although positive impact was highly expected, mental health professionals were exposed to certain challenges in managing this disaster. Just like any other emergency, the September 11 attack was unexpected and the emergency personnel were not very ready for such a magnitude of work (Fullerton, Ursano, & Wang, 2004). Furthermore, the magnitude of the attack was very heavy as compared to available work force. The disaster has led to massive loss of life and thousands of deaths with the impact spreading wide in the community. As a result of this, the few mental medical technologists who were available had to give priority to direct survivors and family members of the diseased before the emergency personnel who in many cases were not directly injured (Fullerton, Ursano, & Wang, 2004).

As a result of the attack, the United States and other states of the world have taken the institutions of mental health care more seriously than before. Mental health educators have also been required to demonstrate certain abilities to effectively prepare for managing such a disaster. For instance, training and certification programs for disaster managers have been emphasized. As a result of this, trauma treatment, crisis interventions, and disaster management are meant not only to target the victims, but also the immediate interveners (Lewis & Roberts, 2002).

CONCLUSION

The September 11, 2001 attack on the World Trade Center in America has been recorded as the most historic terror attack in the American history. As a result of this attack, several groups and individuals have been traumatized physically, emotionally, mentally, and even materially. Although the diseased, the injured, and their families were considered as the most direct victims, several emergency personnel also suffered from long-term or short-term consequences of trauma. Among these, there were the police, media technologists, red cress personnel, and other volunteer rescue workers. Several trauma effects, which were recorded, included fear, withdrawal and detachments, lack of concentration, irritability, sleep disturbance, aggression, hyper vigilance, and flashbacks. Intervention strategies were therefore implemented as spearheaded by the American Academy of Experts in Traumatic Stress, as well as other mental and psychological medical specialists. Although high expectations were laid on these mental and psychological medical experts, the emergency personnel received lesser attention as compared to other direct victims.