



# An Innovative Community-Based Response to the Terror Attacks of 9/11

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## Objectives

- Obtain information about the nature, extent and distribution of response to the terrorist attacks of September 11
- Use this information to plan and implement a community-based intervention program

## Design

- The Children's Health Fund (CHF), a national organization committed to medically underserved children and families, commissioned three Marist polls
  - Completed three weeks, six weeks, and six months after the attacks
- Questions carefully worded to capture parent report of changes in child behavior post-9/11, and parent attitudes about sources of support
- CHF convened a series of public information forums / focus groups near the World Trade Center collapse
  - Coordinated with local community board and city councilman
- CHF implemented a mobile community support unit (CSU) staffed by psychologists and case managers to provide immediate support and counseling near the disaster site and in underserved communities city-wide

## Population

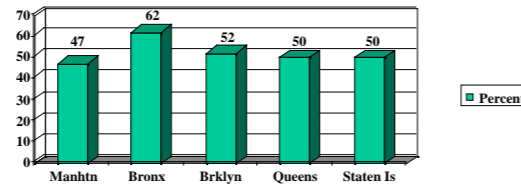
- Standard poll survey methodology used to randomly select and phone interview 466 NYC parents of children age 4 – 18 years
  - Results recorded by child age, family income, and borough of residence
- Open forums held at community locations including schools
- Individuals and families came forward for support and counseling

## Principal Findings

- Concern about safety was ubiquitous among children
  - More than half initially concerned about own and family safety
    - Increased on second poll (coincided with early reports of anthrax cases); stabilized to the initial level on the six month poll

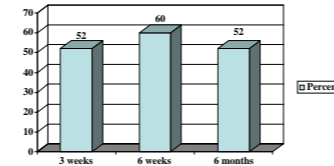
- Child distractibility and preoccupation virtually identical on first and third poll
- These items are markers of risk for post-traumatic stress disorder
- Overt signs of distress subsided over the six month period, including sleep problems, school refusal, and sadness
- Subtle signs increased, including "clinginess" (marker for regression), and physical complaints (somaticizing)
- Minimal variation by borough (proximity to the event), family income, or child age
  - Sadness, anxiety, and school refusal highest in the city's poorest borough, the Bronx
  - The Bronx also reported the lowest level of support from family and friends

Concern About Safety

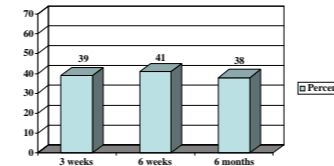


- Community forums revealed enormous concern about air quality
  - Anger and mistrust about government reports that minimized nature, level, and impact of airborne contaminants
- Parents prefer help in typical settings like schools rather than mental health centers
  - Parents did not receive enough support from their child's school
  - Teachers and school administrators wanted help and support to be better able to deal with child and parent concerns
- Those that sought mental health services had difficulty accessing treatment
  - Outreach in communities is more effective than print and broadcast media
- Clinical presentation characterized by depression, anxiety, anger, and interpersonal conflict
- Clinical need more evident several months after the attack than initially

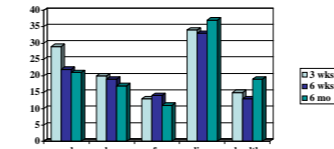
## Child Concerned About Safety Post 9/11



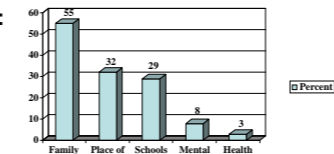
## Child Distracted and Preoccupied Post 9/11



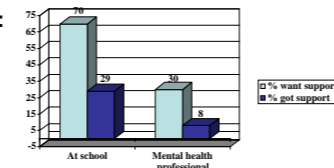
## Other Child Reactions Post 9/11



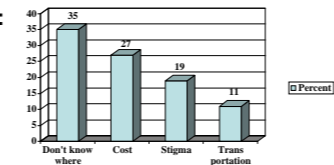
## Six Months After: Sources of Help and Support



## Six Months After: Gaps in Help and Support



## Six Months After: Barriers to Mental Health Services



## Discussion

- Most comparable prior event: 1995 Oklahoma City bombing
- In Oklahoma City, the introduction of an agency to facilitate school-based services delayed service delivery (1)
  - Timely response is essential to meet needs
  - The school calendar imposes additional restrictions
- Resources from Federal Emergency Management Agency (FEMA) and American Red Cross (ARC) most available immediately after the disaster (2)
  - Clinical need within 100 miles of Oklahoma City continued years after the bombing (3)
- Increased television and other media exposure may increase risk for post-traumatic stress disorder (3,4)

## Implications for Practice and Policy

- Emergency policy continues to focus on "Ground Zero" with short-term (3-6 visit) interventions that begin immediately and are soon withdrawn
  - Long-term response left to the state and locality
- Lessons from Oklahoma City were not applied to 9/11 response
  - Those who need clinical services are not well served in so few visits
  - Need for clinical services may not be apparent until after FEMA and ARC resources have been withdrawn
  - Timetable for these agencies should reflect field experience
- Local mental health capacity limitations exacerbated by disasters
  - Disaster preparedness includes an adequate mental health infrastructure
- Excessive focus on mental health pathologies common reactions to extremely uncommon events
  - May discourage seeking help
- Special effort should be made to reach disadvantaged populations including the poor and medically underserved
- Government reports should not attempt to minimize or deny problems

- Support services should be available in schools immediately after a terrorist incident and continue thereafter
  - Emphasis should be on school-wide support services
    - Clinical intervention available as needed
  - Documentation and research can be done in context of service delivery
- Health professionals should watch for symptoms reactive to a terror attack
  - Possible new or exacerbated respiratory problems should be monitored
  - Parents need anticipatory guidance to better identify signs of child distress
- Television coverage should avoid excessively exposing children to repetitive violent images
  - Parents should monitor television viewing following terrorist incidents

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