First-Hand Lessons from Ground Zero, 20 Years After

psychologytoday.com/us/blog/darwins-subterranean-world/202109/first-hand-lessons-ground-zero-20-years-after

Key points

- As the 20th anniversary of Sept. 11 approaches, we need to take stock and think carefully about lessons learned.
- We don't like to think that disasters are likely. Yet such denial is a major barrier to effective preparation for what is sure to come.
- Moving forward, we need to take steps to be prepared for mass casuality incidents that are both within and outside of our imaginations.

This post is a guest piece by Dr. James Halpern.

On Sept. 11, I led the first American Red Cross mental health team to Ground Zero looking for the “walking wounded.” On Sept. 12, I began a week-long assignment managing the “Missing Persons Hotline,” and over the next few weeks, I escorted family members of first responders to Ground Zero as they looked over the “pile” to see where their loved ones perished. For the next year, I supported memorials, funerals, counseled survivors, first responders, reporters, government officials, and clergy who worked at the site. Because most of us who responded were shocked, confused, disoriented, vicariously traumatized, and there was so little research and guidance, I went on to found the Institute of Disaster Mental Health at SUNY New Paltz. I also continued to write, train, and present on Disaster Mental Health locally, nationally and internationally and cowrite three textbooks on DMH. I continue to serve as a Red Cross volunteer and member of the Board of Directors of the Hudson Valley Chapter. Here's what I've learned and taught.

Source: National Park Service / Wikimedia Commons

Lesson 1: Overcoming denial to improve planning and preparation

On May 18, 2001, there was a “tabletop exercise” at the American Red Cross Greater New York location in Manhattan. The topic was how our chapter would respond to an “aviation incident” in the New York metropolitan area. How would we get to headquarters? Who would be our clients? How would we contact survivors? Principal topics for the exercise were jurisdiction, organization, and hierarchy. There are local, state, and federal authorities, emergency management, police, firefighter, airline and FBI officials, and the National Transportation Safety Board. Under the Family Assistance Act of 1996, after a mass transportation incident, the Red Cross is responsible for “family care and mental health.” The scenario presented was an air traffic control tower accident at a Queens airport resulting in two passenger planes hitting a populated area in New York City, leading to hundreds of casualties. “What!?”most of us complained to the exercise organizers. “We should be planning for a disaster that might actually happen and not some preposterous scenario.” Although most of us were experienced disaster responders, we could not accept that this was even a possibility. If we were in denial, how can we expect others in the general population to be more connected to a potential reality and to plan and prepare effectively?

The simplest answer to why we don’t adequately prepare for disaster is denial. We can protect ourselves or think we are protecting ourselves if we refuse to see the threat. Denial occurs when someone is faced with a fact that is too uncomfortable to accept and rejects it despite overwhelming evidence. Since we are surrounded by danger, and it is not helpful to be in a constant state of fear, denial is a basic and useful defense mechanism—but only up to a point. Denial is an obstacle to substance abuse treatment and can increase the risks of heart disease and cancer when people ignore the warning signs of disease. And denial can keep us from being prepared for and planning for disasters.

We are more likely to deny and inadequately prepare for disasters that are not visible nor understandable (Burmudoi and Nagai, 2017). These factors contribute to the poor initial and continuing response to COVID-19 and our inability to take bold action on climate change. We can’t see or understand a virus. Climate change makes disasters bigger, badder, and longer, but is neither seen itself nor easily understandable. (We don’t see the greenhouse gases in the atmosphere). People don’t pay attention to a threat if they lack early warning, information, skills, or knowledge (Liu, Li, Fang, Zahn, 2017). Our response to the threats of pandemic and climate change are made worse by both rumor and misinformation. While there have always been rumors and misinformation surrounding disaster, it has gotten much worse with social media and extremist ideologies.

Good clinicians understand the power and danger of denial and we can help clients to overcome it.

Lesson 2: Weighing health vs. financial costs

There were many more victims than the 3,000 who died on Sept. 11. Tens of thousands of men and women worked through the recovery efforts at Ground Zero, recovering more than 30,000 body parts, at extraordinary personal costs. Residents moved back to a

neighborhood that was chaotic, noisy, filled with armed law enforcement and national guard, sirens, and a toxic stew of chemicals, debris, and smoke. Authorities knew that the air was not safe at Ground Zero and yet they reported that it was. Why? It is likely that a calculation was made that shutting down all of lower Manhattan, including Wall Street, would be too costly. Did they make the right decision? Was opening up New York City while the air was still unsafe the right decision from a cost-benefit analysis? It may take decades before we know the full extent of the physical and emotional trauma to the first responders, workers, their families, residents, and others who were exposed to the toxic World Trade Center aftermath brew. The World Trade Center Health Program is currently treating over 100,000 people with certified health conditions, including 20,000 with cancer.

I am one of them.

Declaring that the air was safe and opening lower Manhattan saved livelihoods but lost lives. If the air was more or less toxic or the economics more or less impactful, would the decision have been different? When would it have made the most sense to have opened lower Manhattan? There has been no transparency about that or similar decisions and we are all still in the dark. Perhaps we always will be.

Lesson 3: The increasing importance of remote mental health and call centers

On Sept. 12, 2001, and for over a week from that date, I managed the Missing Persons Hotline, set up in the call center for New York's public television station, Channel 13. People from all over the world called in to find out the status of their loved ones, many of whom were expected home but had not arrived. Hundreds of counselors made thousands of calls to frightened, anxious, and grieving relatives. At that time, it was one of the largest mental health responses to disaster. It was also the first significant disaster crisis hotline. Beginning on the evening of Sept. 11, American Red Cross of Greater New York licensed mental health volunteers manned the call center. Most calls were inquiries about missing persons from friends and family. The operation had two goals: to develop a database of missing persons and to provide crisis counseling. The vast majority of counselors did an excellent job of providing assistance for long hours and returned to help for many days. However, some volunteers decompensated either during training, during the response, or at the end of their shifts. Some had to leave the assignment even before they started answering phones.

Since then, the Red Cross and other state and local agencies have organized mental health responses to an increasing number mass violence, natural disasters, and other large-scale catastrophic events. Since 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) has supported a national Disaster Distress Helpline and communities all over the country have counselors available by phone to assist COVID survivors. Climate change will bring us an increasing number of Mass Casualty Incidents (MCIs) that will necessitate phone counseling. They will include: transportation accidents, shootings, fires, floods, structural collapses, hazmat/industrial accidents, radiological events,

public health emergencies, and heatwaves. At the Sept. 11 call center, we received heartbreaking calls, some before there was enough time to consider the research or to consult with others on clinical wisdom. Please consider the following actual queries to the Sept. 11 call center. Take a few moments and think about what you would say to a client who asked:

- *When will I know with certainty if my loved one has died?*
- *How could God have let my loved one die?*
- *Why did this happen to my loved one? She was such a decent and loving family member.*
- *Will I or my family ever be whole again?*
- *Do you think that when the plane crashed or building collapsed my loved one experienced fear or pain?*
- *What should I tell my child about why her parent is not ever coming home again?*
- *I am pregnant but now that my husband is dead, I don't know if I should keep the child. What do you recommend?*

Mental health professionals can do better in helping our clients to prepare for disaster, as well as engage with them in conversations about navigating health and financial risks when we do not have answers or all the accurate information. We can be better prepared to respond to the increasing number of MCIs—both within the bounds of our imaginations and beyond—coming our way by getting disaster mental health training for in-person and remote counseling.

James Halpern is Professor Emeritus and Founding Director of the Institute for Disaster Mental Health (DMH) at SUNY New Paltz.

References

Liu, D., Li,Y., Fang, S., & Zhang, Y. (2017). Influencing factors for emergency evacuation capability of rural households to flood hazards in western mountainous regions of Henan province, China. International Journal of Disaster Risk Reduction, 21, 187-195.

Bormudoi, A. & Nagai, M. (2017). Perception of risk and coping capacity: A study in Jiadhal Basin, India. International Journal of Disaster Risk Reduction, 21, 376-383.