Tuesday Morning September 11, 2001: The Green Cross Projects' Role as a Case Study in Community-Based Traumatology Services

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SUMMARY. This article sites several post-attack, national surveys indicating negative mental health consequences as a context for considering the recent mobilization of the Green Cross Projects (GCP) in New York's lower Manhattan area. The GCP is a humanitarian, disaster mental health organization that provides crisis intervention to organizations

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(public and private) affected by traumatic events. After noting the history, purpose, and structure of the GCP, the article describes its recently completed mobilization beginning with the invitation by a large, local service employee union. Based on the invitation an agreed upon mission was established with six measurable objectives. This is followed by a description of what happened, who and how many were served and trained. The final section of the paper discusses the lessons applied from traumatology and the lessons learned that should be applied to future community-based, organizational assistance following a major disaster.

KEYWORDS. Attack, national surveys, mental health, Green Cross Projects, GCP, New York, Manhattan, humanitarian, disaster, crisis interventions, traumatic events, traumatology, community, assistance

At 8:45AM on September 11th in the first year of the millennia America's sense of security was changed forever. American Airlines Flight 11, a Boeing 767 carrying 92 people, crashed into the World Trade Center's North Tower. Eighteen minutes later United Airlines Flight 175, also a Boeing 767, with 65 people aboard also crashed into the World Trade Center at the South Tower. Two other tragedies were about to happen involving two other locations and two other planes. Everyone in lower Manhattan was focused on the horror of the Trade Center towers.

Fifteen blocks away at the Service Employee International Union Local 32B-J building on Avenue of the Americas at Grand Street, over 800 union staff (those who administer programs for the union members) watched in horror. Most witnessed dozens of people jump from the Towers to their death, the stream of rescue workers responding to the disaster, the stream of people running from the towers, and then the collapse of the Towers onto these brave responders and so many others. Local 32BJ union members are building service workers, i.e., janitors, window cleaners, elevator operators, and security guards. More than 1500 members of 32B-J worked in the World Trade Towers. Another 7500 members were working in Manhattan below 14th Street, blocks from Ground Zero. Not only was 32B-J suffering its worst single day of loss of life, its union members, professional staff, managers, and general

staff were in emotional shock. They required a massive assistance effort. Through professional connections they learned of the Green Cross Projects and requested immediate assistance.

In a September 14th letter to the Green Cross Founder (first author) and current President (second author) requesting assistance, Mary Ellen Boyd, the Chief Executive Officer of the Union's Health Fund, explained the situation described above, and noted that

> We have a small Employee Assistance staff and a group of volunteer therapists to help us deal with the situation but we are totally without expertise.

Her letter went on to say:

> Your assistance would be invaluable. Our employees and members are suffering with many different symptoms and their families are reporting difficulties as well. To add to our complications, will be the economic realities our members will be facing.

Ms. Boyd herself would be forced out of her residence because it was in the blast area near the World Trade Center.

PROXIMAL VERSUS DISTAL IMPACT

Most people recall easily where they were and what they were doing when they learned of the September 11th terrorist attack. It is one of the darkest days in the history of humankind and certainly the United States. To purposefully kill so many innocent people in such a dramatic way changes the formula for how Americans calculate a sense of safety, security, and freedom. The subsequent threats of bioterrorism and the emerging troop deployments and military actions against the Taliban in Afghanistan make it all the more obvious that we are now in a new era.

What are the varying degrees of impact of this terrorist event, depending upon where one lives? Figley (2002) has noted how the Perpetrator-Innocence-Connectedness (PIC) score can be applied to answering the question. Developed as a shorthand way of estimating the degree of distress that groups may experience from a specific traumatic event (Figley, 1985), the score is only a rough measure and does not take into account the cumulative effects of traumatic events. As illustrated in Table 1, the PIC score is an estimate of the magnitude of challenges in coping with a

TABLE 1. The Perpetrator-Innocence-Connectedness (PIC) Score

		Degree of Innoncence of Victims		
		Low (job-related) (1-5)	Medium (civilians) (6-10)	High (Children) (11-15)
Degree of Perpetration as Perceived by the Victimized	HIGH (5) (Terrorism)			
	MEDIUM HIGH (4) (Violent Crime)			
	MEDIUM (3) (Malfeasant Accidents)			
	MEDIUM LOW (2) (accidents)			
	LOW (1) (Natural Disasters)			

Connectedness: 5 = No connectedness, 4 = Very vague, 3 = Moderate, 2 = High, 1 = Very High

particular traumatic event and is determined by simply multiplying the innocence factor (1-15) by the perpetrator factor (1-5) and dividing by the connectedness factor (1-5).

In contrast to a natural disaster, which is random and unpreventable (Doherty, 1999), terrorist acts are purposeful and can be directed at everyone present, including innocent children. In contrast to a natural disaster in which few, if any, died, the terrorist acts on September 11 may have killed as many as 6,000, including children and other innocent people. However, one of the most important differences between a natural disaster and a terrorist act is the connectedness factor. The connectedness factor, which is determined by estimating how much the respondent identifies with the helpless and victimized, can greatly affect the degree to which one feels traumatized. High identification, including those with relatives and friends who died, would be the most difficult to overcome.

In general, human-caused trauma engenders more psychological harm than natural disasters and accidents (Figley, in press). Those affected realize that their traumatization experiences could have been prevented, and that is what makes the event and its impact harder to accept. When victims are specifically targeted, it makes it difficult to come to terms with the traumatic event. The most difficult trauma to overcome, how-

ever, is being "caught in the crossfire," because the situation could have been prevented and because the intended target was someone else. This is the case in the instances of terrorism.

The new period initialed by the attacks of September 11th is marked by the experience of heightened levels of fear, uncertainty, and insecurity by a large number of Americans (Institute for Social Research, 2001). In a recent survey of American consumers the University of Michigan Social Research Institute found that although more than half reported that the terrorist attacks had no effect on them, a larger than expected number said otherwise. About 20 percent of all consumers surveyed between Sept. 15 and Oct. 7 reported that their sense of personal safety was shaken a "great deal" by the attacks, and 29 percent reported that it was shaken "a good amount." As we would expect given the location of the attacks, the eastern US was more affected: 24 percent of the residents of the Northeast and Southern regions reported that their sense of personal safety was shaken a great deal, compared to 14 percent of residents of the West and North Central regions.

A series of nationwide telephone surveys, conducted by the Princeton Survey Research Associates (2001) for the Pew Research Center (http://www.people-press.org/midoct01que.htm), found that although depression, sleeplessness, and fear were high immediately following the September 11th attack, the majority of Americans have recovered. In mid-September, 71% of those polled agreed with the statement that "In the past few days, have you yourself felt depressed because of your concerns about terrorist attacks or the war against terrorism?" By early October the number who said "yes" dropped to 42%. A month later only 31% answered replied affirmatively to this question.

Similarly, in Mid-September 33% answered, "yes" to the question. "In the past few days, have you had any trouble sleeping because of your concerns about terrorist attacks or the war against terrorism?" The percentage dropped to 18% in early October , and in the latest surveys conducted in mid-October, the percentage is only 13%. Yet the percentage of those who are "very worried" that "there will soon be another terrorist attack in the US" appears relatively unchanged since the question was first posed in early October. At that time 28% were "very worried" and 45% reported they were "somewhat worried." In mid-October 27% responded as "very worried" and 40% "somewhat worried."[1] Another survey found similar patterns of response (PSRA, 2001).

It was within this cultural context that the Green Cross Projects was contacted to help out in New York City. The purpose of this article is to describe how one group of trauma practitioners responded to requests for

assistance from New York immediately following the attack. The way in which this response was informed by the existing knowledge base in traumatology, and what we can learn from it that can be applied to future catastrophic incidents, are highlighted.

GREEN CROSS PROJECTS' RESPONSE

The Green Cross Projects is a membership-based, humanitarian assistance program providing traumatology services to individuals, groups, and communities recovering from disasters and other traumatic events. The Green Cross Projects (GCP), was established in response to another terrorist attack in the US, the Oklahoma City bombing of 1995 (Figley, 1995). Since that time GCP has responded to events that have included a website for the war in Bosnia (1996), the responders to the Port Arthur shootings in Tasmania (1996), South Africa's Truth and Reconciliation Commission (1996), services and consultation for the State of Florida (Tropical Storm Josephine, 1996-1997), consultation on the Arkadelphia Arkansas tornado (1997), consultation on Northern Ireland (1999 and 2001), consultation on the Littleton, Colorado (Columbine) Shooting (1999), consultation on the war in Kosovo (2000), consultation and full mobilization in response to the terrorist attacks on New York City (2001).

The President of the GCP is responsible for recognizing that disaster of sufficient magnitude may require the services of the GCP and places the organization on standby status. As a result a cascade of actions are set in motion to alert the GCP membership of the event, inquire about membership availability to serve, and alert potential hosts in the affected area of the GCP services available.

Mobilization is also declared by the President of the GCP based on (a) a specific invitation from a host organization, (b) a specific and attainable Project Mission is identified through interaction with the host, (c) availability of sufficient resources and members, and (d) identification of key individuals to serve in the key disaster services roles.

Consistent with disaster management protocol, there was an Incident Commander (initially the second author and later the third author), Operations Manager (the second author), public relations specialist (the first author), team leaders with five service providers for each team.

The Incident Commander (IC) is in charge of the Green Cross Project deployment cadre and is the supervisor for the Operations Manager, the Public Relations Specialist, and the team leaders. The IC follows a stan-

dard protocol for the operation, maintains a daily log, and is the point of contact (systems interface) with the host organization (sponsor).

The Operations Manager (OM) is responsible for the day-to-day service provision during the mobilization. This includes but is not limited to insuring that all service-related paper work is completed, all logistics and planning is complete, and all transportation needs are coordinated. The OM serves as the assistant to the IC and represents the IC and performs all other duties specified by the IC.

The Public Relations Specialist is responsible for representing the Green Cross Project (mobilization) to all entities outside the operation. This includes the news media, other organizations involved in the operation, and the general public.

These roles are consistent with the incident command structure utilized by most disaster-oriented organizations. Unlike other organizations, however, the GCP operations manual requires that all teams also included a compassion fatigue specialist (see Gentry, this volume) responsible for debriefing, defusing and the general morale of the team.

In anticipation of the request for services, the second author placed the GCP on standby and identified two teams of 6 members who were prepared to go immediately to New York. Two compassion fatigue specialists were among the team members. After the September 14th letter was received by the GCP, the second author declared the mobilization, established the New York Green Cross Project, dispatched the advanced party of GCP workers to arrive September 16th and begin providing services the next day following an orientation by the Incident Commander. The Incident Commander had met with the Host (32B-J) the previous evening and together they established the full mission of the mobilization for the NYGCP.

It is vital that the GCP or any organization providing assistance be very clear about what the affected community needs and wants. Immediately following the Oklahoma City bombing in 1995, for example, the first author met with public and private officials to determine what would be most needed by those responsible for helping the bombing victims, their families, the rescue workers, and other affected. It was determined that training was the most acute need.

Within a few months, more than 1,000 professionals received at least one workshop of training and fifty-eight completed the entire five-course program of training and received a certificate as a Registered Traumatologist (Figley, 1998).

Those Registered Traumatologists became the founding members of the Green Cross Projects (GCP) and were ready to apply the lessons they

had learned both in the classroom and in their own State in helping people recover from terrorist attacks. As it turned out, Oklahoma sent one of the largest contingents of traumatologists to New York, second only to Florida.

The program of training they completed was adopted by the Florida State University's Traumatology Institute as the Certified Traumatologist certificate program (Figley, 1998). Over the years the Institute established three other certifications: Master Traumatologist, Field Traumatologist, and Compassion Fatigue Specialist. With certification comes automatic membership in GCP.

Members practice traumatology guided by the Academy of Traumatology standards of practice and ethical guidelines (Academy of Traumatology, 1999). The Standards are located at the Green Cross Foundation's web site at (http://www.greencross.org). Since June of 1998 a Board of Directors has governed the GCP. In addition to an annual meeting, a web site (http://www.fsu.edu/~gcp/) informs members throughout the world. During the New York City mobilization, for example, there were updates on what was happening, copies of various messages to members, press releases, news accounts, and other helpful information for those who were activated as well as others who were interested. Also, members receive the international journal Traumatology in both written and virtual form at (http:// www.fsu.edu/~trauma/).

The Mission of the GCP is to provide immediate trauma intervention to all areas of the world when a crisis occurs either through its members individually or through mobilization (World Health Organization, 1997). Most often GCP members provide humanitarian service in their local communities. However, GCP is unique in its ability to activate large numbers of members to respond to major disasters, such as the one that affected the island of Manhattan, New York City on 11 September.

Deployment Mission

The Mission of any GCP deployment is to transform Victims into Survivors. Victims may have a sense of helplessness that limits their ability to cope with future events, traumatic or otherwise. Survivors, on the other hand, use lessons learned from the traumatic event to heal and become stronger as a result. Immediately following a traumatic event victims struggle to address five fundamental questions (Figley, 1985):

1. What happened to me (us)? This question can be applied to oneself, one's family, company, neighborhood, city, or country. This question is the most fundamental one in the processing of trauma mem-

ories and is associated with the experience of shock, disbelief, disorientation, and confusion. GCP service providers help clients to recognize what has happened to them. Most often this is achieved by encouraging them to talk about their experiences or to depict them in some other way such as through the modalities used in expressive therapies (e.g., poetry, drawings).

2. Why did it happen to me (us)? This question is at the heart of one's sense of responsibility for either the cause or consequences of the event, or both. Survivors often associate their actions preceding the traumatic event with feelings of guilt. This was certainly the case with those who had worked in or near Ground Zero. GCP service providers create an opportunity for the traumatized to re-evaluate their actions,
3. Why did I (we) do what I (we) did during and right after this disaster? This second-guessing and self-analysis is central to acquiring some degree of mastery over the memories and events that were or still are traumatic. GCP service providers gently encourage survivors to address such difficult and often troubling thoughts associated with self-evaluation. Often hearing other survivors talk about their misgivings enable them to reassure the others while, at the same time, reassuring themselves.
4. Why have I (we) acted as I (we) have since the disaster? This question represents an effort to self-assess to determine if what is being experienced is cause for alarm and requires the help of others. It also suggests that the need for mastery of what may be described as being obsessed with the traumatic event. GCP service providers conduct a wide variety and large number of public education sessions that discuss the immediate and long-term psychosocial consequences and opportunities following dangerous and horrifying events. These sessions not only address how to handle these responses as a survivor, but also how to help friends and family to differentiate what are normal reactions and coping from effects that require more attention and perhaps professional assistance.
5. Will I (we) be able to cope if this disaster happens again? The response to this fundamental question is an indication of if and how much the survivor has learned from the trauma and its wake. The answer to this and the other questions discussed above forms the survivor's "healing theory" (Figley, 1985; 1989) and enables him or her to move on with life and let go of the emotional reactions as-

sociated with the memories. This last question is the most challenging for GCP service providers because only time and extensive discussion and processing enable survivors to develop their own healing theory.

Standard Mobilization Procedures

The GCP works with the host or client to clarify the mission of the deployment and specify measurable and attainable goals. Typically the services provided are provided in waves:

Wave I (Days 1-10 following the disaster): Crisis stabilization, contacting local GCP members to establish a chapter for continuity of care.

Wave II (Days 5-15): Stress management, social support, and orientation of Management.

Wave III (Days 10-20): All the above plus training, assessment and referral, and family resource development.

Wave IV (Days 15-40): All the above services plus grief and loss consultation and counseling.

Specific Services Provided

The GCP responds to requests from individuals, organizations, and other entities following a traumatic event. The requests can include any or all of the following:

1. Crisis assistance and counseling: helping those in shock get back on their feet and access their natural coping methods and resources.
2. Assessment and referral services: identifying who is recovering properly from the traumatic event, who is not, why they are not recovering and what additional or other services are needed when and by whom.
3. Orientation and consultation to management: educating management about the immediate, week-to-week, and long term consequences of traumatic events for individuals, work groups, families, and larger systems.

4. Training, education, and certification: preparing management, human resources, employee assistance professionals, and service providers with sufficient guidance and competence to first do no harm to the traumatized and help them recover.
5. Family resource management designing and implementing programs for strengthening and promoting family wellness in the wake of traumatic events, with special attention to young children.
6. Long-term trauma counseling: helping those unable to recover quickly from the trauma by providing individual and group trauma and grief counseling.

These services are provided over varying periods of time and performed initially by members of a deployment team. TGCP service providers are transported into the impacted area within hours after the request is made. They stay from between 3 to 6 weeks or until local GCP members can relieve them.

THE TERRORIST ATTACK AND THE NEW YORK CITY GCP MOBILIZATION

Initial Mission, Objectives and Outcome

Prior to the initiation of services for the Host (i.e., Local 32 B-J) it was agreed that the Mission of the Green Cross New York Project at 32B-J is to help the management, staff, employees, and membership mitigate the impact of traumatic response induced by the September 11, 2001 attack on the World Trade Center. To accomplish this mission, Green Cross New York Project developed the objectives outlined below. While the Host has and will benefit from all the objectives, the first three are most relevant to their immediate needs.

Objective #1: Provide immediate critical incident stress management and crisis-oriented services utilizing: scheduled group defusing/educational sessions with fund and union staff; scheduled individual defusing/educational sessions with fund, union staff and members; unscheduled individual and/or group sessions with fund, union staff and members, and crisis interventions as needed.

Outcome: Green Cross Traumatologist volunteers facilitated 76 group defusing/educational sessions from September 17 through October 14, 2001 with the fund and union staff. The length of group sessions ranged

from one to one and a half hours with 2 sessions going for 4 hours. Total attendance for group sessions was 635.

Green Cross Traumatologist volunteers facilitated individual defusing/crisis interventions from September 17 through October 14, 2001 with fund, union staff, and members. The length of individual sessions usually ranged from 20 minutes to 1 hour but on occasion ran longer. There were 2,159 individual defusing/crisis interventions. Individuals with more than critical needs were referred to their Employee Assistance Program so those needs could be met. There were approximately 30 referrals to EAP by GCP personnel. The 32B-J EAP employees were a tremendous help to our GCP volunteers. The total number of GCP contacts with 32B-J staff and members was 2,794.

Green Cross Project trauma specialists' primary function on a deployment is to assess, stabilize, and refer as needed. During the assessment and stabilization process at 32B-J, more specific needs were discovered. The family members that had lost loved ones in the attack on the World Trade Center Towers faced a very difficult situation. Most of them will not have the body of their loved one for formal final services. This usually results in an ambiguous loss process. Dr. Pauline Boss from the University of Minnesota is an expert in helping family members process through ambiguous loss. Dr. Boss brought two teams of ambiguous loss experts from her program to New York City to work with affected 32B-J families.

The first team of four ambiguous loss specialists and Dr. Boss were on site from September 26 through 29, 2001. While on site, the team was able to identify family members that had lost loved ones and helped them begin processing through their ambiguous grief. The University of Minnesota team was able to contact and assist four family members during their first deployment.

During the University of Minnesota's second deployment, from October 10 through 14, 2001, Dr. Boss and a team of four held a training program on ambiguous loss. Twenty-three local mental health professionals attended the training. This training was put to use on Saturday October 14, 2001, when eight families were brought together at 32B-J to begin developing their support system. Approximately 25 adults and 10 children attended this session. Feedback from the family members in attendance was positive indicating that this session was much needed and they would like to have more in the future.

Objective #2: Provide a five-hour course in basic care for the traumatized to 100 licensed mental health providers who will form the basis for a referral networking system working with the Employee Assistance Pro-

gram at 32B-J. Provide additional courses on traumatology as needed and requested.

Outcome: Green Cross Project trainers provided four sixteen-hour trainings for certification as Registered Traumatologist to 69 mental health professionals. The professionals trained were identified by the Host (Local 32 B-J) through their EAP provider network. Although GCP had set a goal of 100 trained traumatologists, the Host was satisfied that the number of providers trained (69) would be able to sufficiently manage union staff and members' needs in the short term. GCP offered to provide additional training sessions if so identified by the Host. Training included basic care for the traumatized, as well as self-care for the mental health professionals while working with the traumatized. Of those mental health professionals, 45 are part of 32B-J's Employee Assistance Program. The other 24 have indicated that they will volunteer their services to 32B-J as needed.

The first training was held at 32B-J during the week of September 23rd through 29th, with 6 trainees, 4 from 32B-J EAP and 2 volunteers. The second training, also at 32B-J, was held during the week of September 30th through October 6th, with 39 trainees. Those included 17 staff from Steinway Child and Family Services, 2 from Fordham-Tremont Community Mental Health Center, and 3 from Long Island College Hospital and 17 volunteers. Those three facilities are referral sources for 32B-J EAP.

The third training, during the week of October 7th through 13th, was held at Fordham-Tremont Community Mental Health Center. The 16 trainees included 13 staff from Fordham-Tremont and 3 volunteers. The fourth training, also during the week of October 7th through 13th, was held at Long Island College Hospital. Nine trainees included 6 staff from the hospital and 3 volunteers.

Objective #3: Provide a course on compassion fatigue that will increase self-care for those mental health professionals and others who have provided services to the victims. The compassion fatigue course is designed to help the mental health professionals effectively manage their own stress so that they can continue to provide services.

Objective #4: Establish the headquarters of the New York Green Cross Project, establish the New York Green Cross Projects Chapter, and develop sufficient funding for at least one year.

Outcome: This objective was reached by establishing the headquarters of the New York Green Cross Project at the Host's building on the 23rd Floor. Two banners hung there during the mobilization. Fundraising is ongoing as are efforts to establish the local chapter in addition to two meetings in October. The American Red Cross (ARC) was providing mental

health services at its Family Service Center, and routinely received requests from businesses for debriefing employees. The ARC contacted NYGCP to inquire if GCP would take ARC referrals. Additional GCP trauma workers were deployed to NYC to handle the increased need for trauma services. We anticipate that as routine and a sense of normality emerges in New York City, the need for the Chapter will increase. Trauma specialists recognize the difference between treating traumatic response versus treating mental health disorders, i.e., providing trauma management and coping skills rather than therapy. Collaboration and education in the mental health community are keys to ensuring that the appropriate treatment of traumatized individuals is delivered. The first organizational meeting was held October 1, 2001 at the Chinese United Methodist Church (69 Madison Street, New York City Chinatown District) from 4-6 PM.

In terms of other support secured for the New York Green Cross Project, the distinguished New York City law firm of Loeb & Loeb agreed to provide legal and other assistance for the coming months and particularly to help set up the NY Metro Chapter.

The generous pro bono assistance of Jet Blue, AirLifeLine, and other private aviators made it possible for GCP members to get in and out of the New York City metro area as quickly as possible.

Objective #5: Evaluate the Green Cross Projects deployment standard operating procedures and make needed improvements.

Outcome: An upcoming Annual Membership Meeting will discuss and evaluate the Green Cross Projects deployment standard operating procedures (SOP). A new SOP will emerge from these discussions and the After Action Report prepared by the second and third author. Modifications include use of Incident Command and deployment of compassion fatigue specialists. While a deployment structure had been informally adopted, the Incident Command System had not been used during prior deployments. For traumatologists trained in earlier courses, the Incident Command System was not part of their training. Consequently, only some team members were familiar with incident command. Those who were not familiar with incident command reported that the structure of incident command was too rigid. They had difficulty integrating the concepts of a chain of command system while working a catastrophic event. This created conflict that could have been avoided had the SOPs clearly stated the command structure. The addition of compassion fatigue specialists (CFS) as part of the team was a new concept, implemented for the first time during the September 11th response. The CFS primary respon-

sibility was to ensure that GCP traumatologists providing services were able to manage the stresses of the catastrophic event. A secondary responsibility was to debrief/defuse the management staff. Although the concept of having CFS on the team was embraced by all, the reporting structure created boundary concerns for the CFS. Initially the compassion fatigue specialists were assigned to team leaders, and were directed to work only with members of their teams. When issues arose that included team leader concerns, boundary issues arose and the CFS was faced with a conflict of interest when trying to resolve. In future incidents, a deployment team CFS will report directly to the Incident Commander, and CFS for the trauma services teams will report to the Operations Manager.

Objective #6: Produce at least three reports of the lessons learned and publish them in Traumatology, the Green Cross Projects international electronic journal.

Outcome: The Editor of the Journal (the first author) sent a call for papers and reports from the GCP members who were involved in the mobilization and those who were active in providing assistance in some other ways.

During the thirty-day mobilization to reach the above objectives it became clear that there would be far more traumatized Host members and employees requesting trauma services. Moreover, the Red Cross established a good working relationship with area community-based organizations and mental health professionals to provide services to the traumatized, thus negating the need for establishing a local chapter of the GCP (Objective 4). However, there is ongoing interest and effort in establishing the chapter at the time this article was written.

To accomplish these objectives, Green Cross Project deployed a total of 36 Traumatologist volunteers from September 16 through October 17, 2001. The first week, September 16th through 22nd, 14 were deployed. The second week, September 23rd through 29th, 14 were deployed. The third week, September 30th through October 6th, 13 were deployed. The fourth week, October 7th through 13th, 11 were deployed. To maintain continuity of services, some team members were on site from one week to the next.

In an October 29, 2001 letter to the Green Cross Project's NYGCP project Incident Commander, Jim Norman, the President of the Host organization, Michael P. Fishman wrote:

It has been nearly a week since you left Local 32B-J. On October 19th we held a memorial service at St. Patrick's Cathedral for the 24 missing members. Over 4,000 members attended. In many ways, this memorial brought some closure to the first period of this terrible tragedy. But, I can say in all honesty that we would never have been able to get to this point without your efforts and the efforts of the Green Cross workers.

From the day you hit the ground, Green Cross brought an immeasurable degree of safety and calmness as we dealt with what was for many the most horrible and tragic event of their lives. Time after time, people would tell me how they were struggling to get by and because of some connection with one of the Green Cross volunteers, they were able to continue to assist our members and carry on in their own lives.

It is hard to imagine, in the beginning, that five weeks later we would begin to have some distance from this terrible event and be able to resume some semblance of a normal, although changed, life. For this we owe many thanks to you.

If there is anything we can do to help your organization, or you personally, please let me know. With many thanks.

Sincerely,
[signed]
Michael P. Fishman, President

DISCUSSION

Compared to the Oklahoma City bombing, the WTC attack was in a totally new category of traumatic events. The lessons learned in Oklahoma and in subsequent experiences were a necessary but not sufficient preparation for what the GCP had to face in New York City in 2001.

Unique Factors Associated with the WTC

1. Massiveness

The large numbers of those impacted in the immediate area, which included mental health practitioners, was extraordinary and unprecedented. As a result, GCP resources were strained. Unlike other programs, with traumatized folks trying to help traumatized folks, we were able to rotate fresh workers weekly and provide them with excellent resources during and following deployment. The first thirty days following an incident are ones in which the local providers need time to manage and begin healing their own traumatic reactions. By bringing in traumatologists from other states and countries, local resources are supported through the availability of those who can provided trauma assistance and, in the case of GCP deployment, provide desperately needed trauma recovery training. In addition, rotating workers provided an exposure cap to the amount of traumatic material to which the GCP workers would be exposed. This was critical in the management of compassion fatigue. Because the Host (Lo-

cal 32B-J) had endorsed GCP as its resource for trauma management for staff and members, those needing trauma services were able to adapt to the new personnel when they arrived. (Note: Staggered arrivals allowed from the transition from one trauma worker to the next. At no time were 100% of the workers rotated out with a complete new team starting at the same time.)

War-Like Attack

Never before has any member worked a disaster that was an act of war. Although the Oklahoma City bombing was an act of terrorism, the perpetrator was caught and the potential for more such attacks seemed remote. Even following the first WTC bombing in 1993 the threat seemed manageable and the work of a fringe group. The 9-11 attack was especially troublesome because it seemed to serve as a prelude to other such attacks; that America was mobilizing to face such attacks; that it was the beginning, not an end, of something terrible. Future mobilizations must learn from these lessons and not attempt to apply without question lessons learned from natural disasters, accidents, and lesser crimes. While natural disasters, accidents and lesser crimes may include elements of horror, these incidents have a beginning and an end; they do not have international implications, and sons and daughters do not go off to war. The concept of "collateral damage" has entered our countries' consciousness. Our everyday lives are changed; and for some racial profiling has added another element of horror.

2. Air Quality

Although everyone who worked in or near ground zero were assured that the air was not toxic, that assurance was short lived. Soon, disaster workers and others working or living in lower Manhattan, including 32B-J workers, were feeling the symptoms, most notably persistent coughing. This was associated with a generalized anxiety about other health effects–both short and long-term. Several web sites were established to keep those who had such concerns informed. GCP Incident Command established a policy that its traumatologists were to stay out of the Ground Zero area. While the primary reason was to ensure that GCP workers were not exposed to traumatic stimuli that could inhibit their ability to provide services, a secondary benefit was to limit their exposure to "bad air." During wind shifts that would drift "bad air" northward the Host (Local 32B-J) provided masks to help minimize exposure. Future deployments need to be prepared for such health risks and make adequate preparation.

LESSONS LEARNED FROM GCP'S RESPONSE TO THE WTC DISASTER

At the November 10, 2001 GCP Annual Membership Meeting all of those who participated in the mobilization were honored with certificates. At that time these and other members shared their perspectives about what has happened and the lessons they had learned so far. Among other things that were shared are the following:

1. "Words Shape Beliefs Which Shape Behavior"

The primacy effect, long identified by social psychologists, applies to traumatized people whose initial beliefs often are hard to change. The belief that "God is punishing us," for example, was common among the survivors in New York with whom we worked. We found in this disaster, similar to others, that those beliefs galvanized by the traumatic event, operate in ways that validate the belief. Yet, for some, just hearing someone else articulate such a belief can also lead to actions. We made sure that training included the best ways to approach the traumatized who were just beginning to formulate their initial self-referencing statements vis-à-vis the trauma they had just survived. We were cautious about using such terms as "victims" and discussing symptoms they may experience for fear that it would increase the likelihood of acting and feeling like victims and becoming more symptomatic.

2. Most Traumatized Are Shaken But Not Broken

Were it not for the traumatic event, most of those we helped would not need our help. We expect them to spring back, be resilient, and emerge even stronger and better equipped to cope because of their experiences without experiencing disappointment or pity when they do not. We made sure that our training emphasized the need for trauma workers to approach the traumatized as those in crisis who are expected to get better.

3. Good Therapists Don't Equal Good Disaster Mental Health Specialists

A lesson noted often by Red Cross Disaster Mental Health Professionals (cf., Wee & Myers, 2002) is that Green Cross Project service providers must leave their traditional therapy skills and methods at home. GCP Training includes discussions of what not to do with the traumatized

or those in crisis, in contrast to a client who is re-experiencing a memory of a trauma from many years ago. What works well for the latter does not necessarily work for the former.

4. Assess, Stabilize, and Refer (ASR)

Most people that experience trauma only need assessment and stabilization services. They are able then to get on with their life unless somehow they get the idea that they have some kind of disorder. Training must emphasize this, particularly for mental health professionals who are required to diagnose all clients and rarely work with healthy people. Well-adjusted individuals may, by virtue of their trauma experience, appear to be dysfunctional and indistinguishable from the typical mental health client. However, they are very different and need to be treated accordingly in order to avoid unintentionally conveying to them that they are more impaired than they are in actuality.

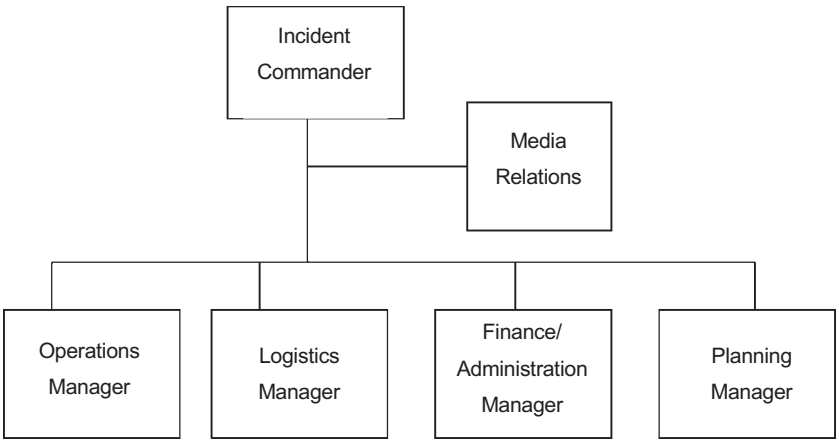
5. Incident Command Works Best in Disaster Response

Incident Command is the most useful approach in working mass casualty or mass population impacted by traumatic events. Training must do a better job of orienting mental health professionals about this approach. It is not taught in graduate programs and rarely discussed in Red Cross training. The Incident Command System (ICS) is used routinely in the public sector at the federal, state, county and municipal levels as a means to coordinate the effective use of all available resources during an emergency, regardless of the magnitude of that emergency (FEMA, 1998) (see: http://www.fema.gov/emi/is195lst.htm). The organizational structure consists of 5 major components (see Table 2).

The Incident Commander is responsible for management on scene. The GCP President (second author) served as the Incident Commander from September 11 through October 2, at which time the third author assumed command. Major responsibilities included management of personnel and equipment resources, maintaining accountability for tasks and safety, and establishing and maintaining an effective liaison with agencies and organizations.

The Operations Manager is directly responsible for ensuring that the mission of the organization is carried out. At Local 32B-J, the third author ensured that the mission–the delivery of trauma services to victims and training to local providers–was carried out.

TABLE 2. Incident Command Organizational Chart



The Logistics Section is responsible for ensuring that facilities, services and materials are available to carry out the mission. During the September 11 response this included the coordination of transportation for all deployed personnel, coordination of hotel rooms, and the acquisition of appropriate equipment (e.g., telephones (land line and cell), computers, and hand held radios). Volunteers from the local area and 32B-J personnel fulfilled this role.

The Finance/Administration Section is responsible for tracking costs and making reimbursements. An example of this during the GCP September 11 response was documenting per diem disbursements, a role filled by Local 32B-J personnel.

The Planning Section is responsible for the collection, evaluation, dissemination, and use of information about the development of the incident and the status of resources. It may also include the development of an Incident Action Plan, which defines the response activities for a specified time frame. During the GCP response to September 11 a daily meeting was held which included the GCP Incident Commander, GCP Operations Manager, and Local 32B-J management. The agenda for the daily meetings was to summarize the activities of the day, evaluate if changes were necessary and brief staff of changes. During the first week of service delivery, meetings occurred more than once per day as needs among the staff and members emerged.

6. A Team Approach Is a Necessity for Effective Disaster Response

There must be trust in the plan and especially trust in the team approach. Working in teams is vital to a successful deployment. To be successful, a team must work with an agreed upon protocol and hierarchy. Effective training for disaster services must teach these procedures while emphasizing the importance of teamwork and maintaining team morale.

7. Compassion Fatigue Prevention Is Vital

Devoting at least one team member to the work of compassion fatigue prevention illustrates how the Green Cross is committed to self-care. The use of a self-care protocol is vital for effective functioning as a team and as team members. The benefits to those served are obvious. Self-care includes learning one's own personal signs and signals of increasing stress and knowing one's breaking point. Training should include simulations of the conditions found in extended mobilizations and insure that trainees develop their own plan for self-care and team care.

8. Retain a Calm Exterior

When working in a crisis setting it is vital to maintain a demeanor that represents stability, confidence, and warmth. This includes keeping one's voice low and soothing, speaking in short sentences and breathing deeply between sentences. Ask closed ended questions until stabilization occurs; then move into more opened ended questions. Training should emphasize the importance of asking permission to be present with someone and to never touch without invitation.

9. Stress Reactions Follow No Time Table

Often there is a delayed impact for some that experience trauma with no fixed time frame. People deal with these stressors when the time is right for them. For some, defenses against fully appreciating what they have survived may take years to subside although they do seem to eventually wear out.[2] Current traumatic events will often awaken memories of older traumas. Therefore, intervention needs to address those aspects of current and past trauma that are disturbing to each individual without pressing them to confront those that are not presently distressing to them. Training should reinforce this lesson and review the literature on delayed stress reactions.

10. Territoriality

In order to cope with these stressors, some exposed to trauma–both victims and workers–find that establishing and maintaining territories makes them feel safe. To do so provides a sense of control in an otherwise chaotic environment. Training should include information about group dynamics and how workers and victims may organize themselves in an effort to feel safer and more comfortable with negative consequences for others.

11. Emergency Professionals and Civilians Respond Differently

Civilians access and respond to their emotions much more readily than emergency professionals. This is due, in part, to the personality and experiences of these professionals, whose work often encompasses regular exposure to traumatic situations. In order to cope they often develop the strategy of trying to maintain a distance from their emotional responses. Also, emergency workers are most often men and their organizations tend to be male-oriented. Future training must include a discussion of these reactions, which are complicated and attribute to a number of dimensions beyond gender. All GCP mobilizations work with both emergency responders and therapists, who must quickly jell as a team in order to work effectively together. Training should include simulations that require practice in forming such teams to work well together.

12. Other Observations

First, it is critical to be able to access local professionals, particularly specialists in trauma, as soon as possible to both ask if there is a need for the GCP and (especially if there is) to recruit them to be part of the Project there ASAP so that they can take over once the crisis is over. Second, it is vital that there is good communication with and among GCP members who are or may be part of the mobilization. Web-based communication worked well for most but not all. Third, media relations are important in making sure that GCP maintains a positive reputation, that there is good public education about the challenges of the mobilization, and (most importantly) communicate with press releases to home town news organizations about their own people serving in the disaster with GCP. This latter element increases appreciation by the community for the worker and by the worker for the recognition.

A FINAL NOTE ABOUT THE SELF OF THE TRAUMA PRACTITIONER

We were so focused on the work at hand that the reality did not catch up with us fully until more than a month after the effort. Along the way we made sure that we wrote about the experience, talked about it, got needed rest and exercise, and did all the other things that we preach to others to do. Because each team had at least one person who specialized in compassion fatigue, everyone was constantly reminded to self-monitor stress levels and to actively practice self-care. Each training included elements of worker self care. There is an on-going assessment of the GCP members who were deployed and a progress report that emerged from the GCP at the Annual Membership Meeting late in 2001.

However, our experiences are consistent with Lahad's (2000) observation that it is vital that trauma workers understand the potential for experiencing the "fantasy of omnipotence" when delivering services and the enormous adaptive challenge following mobilization when the worker returns to life as usual.

On a more personal note, the first and second author, because they are marital partners, had the unusual opportunity to talk a great deal about what we each experienced as "fellow survivors" (Figley, 1985). Each in our own way has recognized the historic importance of the September 11th attack on Manhattan and that we experienced the extraordinary opportunity to apply our collective 45 years of professional experience through the New York Green Cross Project mobilization. The one thing that continued to invade our discussions–starting with our rushed humanitarian flight to New York from Tallahassee on September 16th–was the extraordinary loss of life and shattered dreams. It is as if we were aware of the huge tide of emotion held back by our mission of service.

Will any of us–New Yorkers, Americans, or any civilized human being–fully recognized what the world lost Tuesday morning, September 11, 2001? God help us all.

NOTES

1. The survey consisted of telephone interviews conducted under the direction of Princeton Survey Research Associates among a nationwide sample of 891 adults, 18 years of age or older, during the period October 10-14, 2001. For results based on the total sample, one can say with 95% confidence that the error attributable to sampling and other random effects is plus or minus 4 percentage points. For results based on October

10-11 (N = 400) or October 12-14 (N = 491), the sampling error is plus or minus 5.5 percentage points.

2. Just the week before the attack on the WTC one person, for example, who had worked with survivors of Oklahoma City bombing, had just then decided to address his "bombing stuff."

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