The Enduring Mental Health Impact of the September 11th Terrorist Attacks

Challenges and Lessons Learned

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KEYWORDS

• World Trade Center • Disaster response • Crisis counseling • Barriers to care • PTSD

KEY POINTS

- Training emergency response staff to carry out potentially traumatizing tasks that normally fall outside their scope of work before a disaster or before their deployment and limiting the length of shifts and total duration of work may reduce psychiatric morbidity in disaster workers.
- Clinicians who treat disaster survivors must be familiar with the changing needs of a traumatized population over the course of time.
- Once chronic, posttraumatic stress disorder (PTSD) is a difficult condition to treat and is often comorbid with other major psychiatric disorders. Early interventions administered by well-trained, culturally and linguistically capable clinicians may prevent chronic PTSD and the myriad of comorbid psychiatric conditions that consume a substantial amount of resources in the long-term.
- In the long-term, resources should be allocated to maintain an infrastructure to continue public outreach and psychoeducation while training clinicians in advanced and evidence-based treatments to address the complex comorbidity associated with chronic PTSD.

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INTRODUCTION

On September 11, 2001, terrorists affiliated with the militant group al-Qaeda hijacked and flew 2 commercial passenger planes into the north and south towers of the World Trade Center (WTC) complex in New York City,[1] resulting in the massacre of 2606 victims.[2] The September 11th attack on the WTC was the first act of war on the US mainland since the Civil War[3] and the worst man-made disaster in recent history. Tens of thousands of people were affected by the destruction of the towers and the subsequent rescue, recovery, and cleanup operations.[4]

In this article, the authors review the existing literature on the mental health impact of the September 11th attacks and the implications for disaster mental health clinicians and policy makers. The first section focuses on the demographic characteristics of those affected as well as the state of mental health needs and existing mental health delivery services. Second, the authors describe the nature of the disaster and its primary impacts on lives, infrastructure, and socioeconomic factors. The third section outlines the acute aftermath in the days and weeks after September 11, 2001 in terms of the mental health impact and initial response. Fourth, the authors portray the persistent mental health impact and evolution of services of the postacute aftermath, months to years after the attacks. The fifth and final section lists implications for future disaster mental health practitioners and policy makers.

THE PRE-EVENT COMMUNITY

In 2002, the New York City Health Department established the WTC Health Registry, a database for following people who were exposed to the dust cloud, the fumes from the fires, and the mental trauma of the terrorist attacks.[5] Murphy and colleagues[6] identified 4 exposure groups: rescue and recovery workers, residents, students and school staff, and building occupants and passersby in lower Manhattan. Of the estimated 400,000 individuals eligible for the baseline health survey, more than 71,000 interviewer-administered surveys were completed.[6] Roughly 60% of the respondents were men; 47.3% were aged between 25 and 44 years; and 63% were non-Hispanic white, 11.9% non-Hispanic black, 13.4% Hispanic, 7.5% Asian, and 4.3% other.[7] Of the respondents, 11.3% made less than $25,000 a year, 21.6% made $25,000 to $50,000, 21.1% made $50,000 to 75,000, 34% made $75,000 to 150,000, and 11.8% earned more than $150,000 a year.[7]

An estimated 40,000 to 92,000 people were involved in the rescue, recovery, and cleanup operations.[4] A subsegment of this population is served by the WTC Health Program Clinical Centers of Excellence and shows significant diversity across multiple domains (eg, profession and employment status, state of physical health, cultural identity, and immigration status). Most of the rescue and recovery workers are men, more than half of them are white, and 86% are union members.[4] A recent large-scale study[8] found that of the 27,449 participants, 86% were men, the average age of the responders was 38 years, 66% were married, 17% were single, and roughly 8% were separated or divorced. Roughly 57% identified as white, 11% as black, 31% as Hispanic, 1% as Asian, 3% as other, and 28% were unknown.[8] An earlier study[4] found that of the 10,132 participants, approximately 37% attended college, 14% had graduated college, and 7% had attended graduate school. In this sample, more than 62% had arrived within the first 48 hours of the attack; 84% began working on the sites during the first week, and 91% arrived by September 24, 2001.[4]

Several different professions were represented among the rescue and recovery workers. Protective services and military were among the largest occupational groups to respond to the attack.[8,9] Other represented professions included technical

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