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Editorial

The events of September 11th are now recorded as the most destructive manmade disaster in the history of New York City. In addition to the injured, loss of life, and mass destruction, the psychological trauma experienced by eyewitnesses to the event and those directly affected is unimaginable. As the media kept us abreast of minute-by-minute developments, the rest of the city, the United States, and the world became involved and affected as the events unfolded. The bravery displayed by the rescue workers as they risked their own lives to save others was captivating. The news accounts of the firefighters, police, and EMS have given the world a renewed appreciation for their courage and commitment to saving lives.

In addition to the uniformed officers, countless nurses participated in the rescue and relief efforts. These were men and women who also risked their own lives to provide care and comfort, and to save lives. This issue of the *Journal of the New York State Nurses Association* diverges from the usual scholarly format and focuses on the stories of these nurses. It includes eyewitness accounts from “Ground Zero,” and a nearby hospital; a description of the Red Cross training received by the nurses to enable them to work more effectively; an exploration of crisis theory and nursing education; poetic reflections about the tragedy and life in New York City; and a qualitative study that analyzes the experience of nurses involved in the rescue efforts.

These articles present vivid personal descriptions and express raw emotions experienced at “Ground Zero.”

As we approach the one year anniversary of the World Trade Center bombing, nurses must keep abreast of the expected long-term health effects of the tragedy. These effects include economic strain, psychological disorders, emotional problems, and physical ailments. The long-term health effects such as toxic chemicals on infants born to exposed pregnant mothers; respiratory effects on rescue workers, and post-traumatic stress disorder will need to be identified and studied. Nurses can expect to see those long-term effects in the schools, clinics, hospitals, and communities where we work and live.

As nurses strive to provide care and support to those affected, it is critical to recognize that nurses too are affected and may need to seek assistance with coping. Nurses can seek help through Project Liberty, a funded program that provides free supportive counseling to anyone affected by the September 11th attack. Counseling may include one-to-one or group sessions in a home, school, business, office, or religious institution. As a caring profession, we must remember to care for ourselves first. For further information about Project Liberty, contact (800) 543-3638 or www.projectliberty.state.ny.us.

To all nurses and particularly New York nurses, we want to thank you for your remarkable dedication and caring. You are the pride of America and our nursing profession.

Sonia Baker, PhD, RN, FNP
Phyllis Lisanti, PhD, RN
Guest Editors

Nursing at Ground Zero: A Life-Changing Experience

Maria Gatto, RN, CHPN

September 11, 2001: the day of death, the day the world ended as we know it, and, for me, the day that changed the face of nursing forever.

Reluctantly, we have joined past generations for whom history was made through unthinkable events of death and destruction. Our children and grandchildren will ask us where we were on that fateful, tragic day when terrorists destroyed the Twin Towers in New York City, killing thousands of innocent men, women, and children.

It was the day when “community nursing” came into true focus and resonated profoundly in me, both personally and professionally. It was a life-changing experience that touched both my community and the universal community of humankind.

As nurses, we all have definitions of ourselves based on our degrees, specialties, educational experiences, and background. In the hours and days that followed the attacks, however, I realized that those really had no bearing at all. A nurse is not *what* you are, but *who* you are. In your *being* is your capacity to heal, help, and comfort. Your presence itself means care. During those days, I didn't have to identify myself with a license

or a diploma. I just had to say, “I'm a nurse and I'm here to help.” That gave me the right to go into the heart of the disaster site called Ground Zero.

There was no policy, no procedure, no one to report to or “get report from.” There was no routine, no schedule, no assignment. It was nursing knowledge and skill — the true nursing instinct you find when you're faced with a totally unknown experience. Life hung in the most delicate of balances. Death was everywhere; bodies, minds, and souls were waiting to be resuscitated. The living and the dead needed to be treated with the utmost respect and dignity. No drug book, care-plan, or text could prepare you for this.

I wish to be a voice for all who were there. I want to do justice in my representation, for mine is just one story among the hundreds and thousands that will probably never be told. This is dedicated to all who responded without thought for their own lives, but were there for the sole purpose of giving service to others. It is dedicated to my brothers and sisters in the nursing community, who took an oath to serve, protect, heal, and preserve all life. A community was destroyed that day, but out of the rubble,

humanity experienced a rebirth as we all remembered how precious life truly is.

Terror on the Television

That fateful day began when I was awakened by my mother. I will never forget the look of sheer terror on her face. She screamed, “We are under attack. A plane just crashed into the Twin Towers!” At first, I thought I didn't hear her correctly. Call it shock, call it denial, but I asked her to repeat what she'd said and then ran downstairs to the television. I sat in disbelief, watching the events unfold. I remember thinking, “*This must be just a tragic accident.*” Then the unimaginable happened as a plane crashed into the second tower. The worst fear was confirmed.

A cold numbness ran through my body. I no longer felt shock and disbelief, but the ultimate in terror. In the moments that followed, I felt a pull in my heart. A message from deep inside came through loud and clear: “You must help. There is a great need and a purpose to be served. You must go there.” Confused, but trusting in a faith in God, I prayed for guidance. Where to begin was now the question.

Maria Gatto is employed as a visiting community health nurse at Valley Home Care, Paramus, N.J. and is currently enrolled in nurse practitioner master's programs in Advanced Practice Palliative Care and Advanced Practice Holistic Care at New York University. She also has her own practice in the holistic modality of IGM/Therapeutic Acupressure.

As part of a generation accustomed to going “on line” for everything, I immediately e-mailed my brother and sister-in-law on Staten Island, where my brother, James Gatto, is a sergeant at the 120th Precinct. I was frantic, wondering if my family was okay and if my brother was on duty in that area. As I waited for a reply, I tried the phone. The lines were down, so I just tried to focus myself and *know* that I would be led to whatever I was supposed to do.

A sense of calmness and strength came over me that I had never felt before. I received my personal “moment of clarity,” validating whatever it was I was about to do. I received an e-mail back from my sister-in-law, letting me know that everyone was okay and that my brother was being called in immediately.

I e-mailed her back, pleading that I had to do something to help. I hoped that my brother Jim might be able to help me get into the city, because all transportation was being canceled. I phoned him again and finally got through. He told me that if I really wanted to help, there was only one way to get to Manhattan. The Staten Island Ferry was open to emergency medical and rescue personnel only. I would have to take the ferry and then find my way. “Find my way?” I asked. “What do you mean?” He told me that there would be no one to show me where to go or what to do. The entire city was in shock and total chaos. “You’ll have to make your own way,” he said. “Just follow the smoke, and do what you have to do. If you really need to do this, I will support you 100%. Don’t worry, you will know what to do. God will be with you.”

I immediately got into my nursing gear, packing a bag with an extra uniform and my nursing identification. I told my mother and father, who accepted my decision without hesitation. I was bolstered by their support and confidence in me.

A few days earlier, I couldn’t have said what I would do in a moment such as this, but they knew. It was for them I was volunteering and sacrificing myself. There would be no better opportunity to test my true skills as a nurse and to test — the ultimate test — my faith. Before I left, I hugged my parents and told them I loved them. They took hold of me and then did the hardest thing any parent could ever do. They truly “let go.” I looked deeply in their eyes. No words were exchanged; none were needed. I felt for the first time the unconditional love between a parent and child. A bond not just of blood but of connected being. Fear might have held me in hesitation, but it was their love that freed me.

Ferry to a War Zone

Jim picked me up, and we headed to the 120th Staten Island Precinct. My brother, being a man of very few words but of much quiet strength, was brief but firm in his counsel. “It will be ugly,” he explained. “Nothing you have seen before can prepare you for what you will see now. No one will tell you what to do. *You* must tell *them* what must be done. The chaos of mass destruction has no rules. Make them up along the way in whatever situation you are in.” He opened the car door as we arrived at the precinct. I asked him how could I get back. He smiled and said, “Exactly the way you came.”

I made my way into the terminal and down to the ferry. I could feel my heart beating with a sense of urgency, and my steps got faster as I got closer. I explained to some officers that I was a nurse and needed to get on the ferry. They said to hurry and check in because the ferry was about to leave. I ran up to a woman at a small table, introduced myself, and showed her my license and ID. I jumped on the ferry just before it left. That was it. I was given no briefing, report, direction, or instruction.

There were about six other nurses on the ferry. After brief introductions, we talked about what our plans were and where we would go. One group was going to the Ferry Station, where food and supplies were being handled. Another group was going to Liberty Street, where they needed nurses to volunteer at the site. I looked out at the skyline and for the first time saw the dense cloud of rising smoke. I remembered my brother’s words — “Just follow the smoke.”

We rode the rest of the way in silence. I took a deep breath with my eyes closed. I knew that this was my last moment of nursing in a time of peace.

As the ferry docked, I tried to follow the group of nurses that was going to Liberty Street, but I was distracted by a nurse who tried to talk me into going to help with supplies. I declined, saying that I wanted to go to Liberty Street. We wished each other luck with a hug, and I turned around and followed the smoke.

A Modern-Day Pompeii

I began walking. There were some military officers and police nearby. I went up to a police officer and asked how to get to Liberty Street. He asked for my ID, and then told me to follow the park and make a left. I have never had any sense of direction, and I ended up in the financial district of Wall Street. This was my first introduction to Ground Zero. The story of Pompeii was the first thing that came to my mind. I was the only person walking in streets covered ankle-deep in ash. Papers were everywhere. Buildings, once shining brilliantly in the sun, were now dimmed by thick, choking dust. There was an eerie silence and then the screams of terror-stricken people.

I was directed a few more times and eventually found my way to Liberty Street. Tables were set up like a makeshift but still incomplete MASH unit. There were medical professionals everywhere trying to unload, organize, and care for the rescue workers. I felt out of place, not knowing where to begin.

I heard a familiar voice call out, “Maria?” As I turned around, I saw Angela Appuzzo, one of the clinical lab instructors from New York University. We gave each other a hug, and she asked how I had gotten down here. I told her briefly that I had felt the need to come, hopped the ferry, and walked on down. She gave me a “thumbs up” sign and a big smile. I asked her what I should do. Within two minutes, Angela gave me the basics of setting up triage. I rolled up my sleeves and got started.

All of a sudden, there was an evacuation alert. Rescue personnel and police yelled at us to run. A stampede ensued. That was my last contact with Angela.

When I stopped to catch my breath, a fire chief came up to me and asked if I was okay. I said yes, and we began to talk. I offered my sympathy for the many of his fallen brothers, men who made the ultimate sacrifice in the effort to save others. Before he left, he reached inside his pocket and gave me two postcards of the Twin Towers as a remembrance of that day. We hugged goodbye and thanked each other, knowing this meeting between two strangers would be one of many.

The head medic in charge of volunteer emergency medical personnel at the disaster area asked me if I would help him get together a team of a surgeon, an anesthesiologist, and nurses to set up a triage station at Liberty One. I immediately said yes. I walked into an abandoned hotel and began to recruit the team.

The response was instantaneous. I called out for exactly who I needed, and a team stepped forward. We were then transported in an

*“Ground Zero was a craterous void,
from which were emanating the flames of hell
and the smoke of the consumed.”*

emergency medical ambulance to Liberty One. As we drove through the streets, hundreds of New Yorkers cheered us on and waved American flags, held up signs of support, and came up to the windows, handing us food and thanking us for our courageous efforts. It was overwhelming how, in the wake of this disaster, the spirit was not of defeat.

When we arrived at Liberty One, we began to set up the supplies that were being delivered. Then the inevitable happened again. When we were nearly finished, we were told to evacuate the building due to its structural instability. We were to go to an outside triage area to avoid buildings that were determined to be unsafe.

Relief at Ground Zero

We were organized in medical teams, closer to the rescue workers but still blocks away from Ground Zero. It was now very dark, and huge lights were brought into the area, illuminating the streets. I became removed from the confusion around me and just observed. I wanted to assist as much as possible, so, accompanied by a doctor, I began passing out Gatorade and sandwiches.

We were approached by a physician who told us they were desperate for relief at Ground Zero. So we were brought into the heart of the Twin Tower collapse zone. The doctor brought us down to Firehouse 10 at Greenwich and Liberty Streets and announced that relief had arrived. Then he left.

I stood there in amazement. The front door and wall had been blown out. It was dark, dim, and filthy, with thick layers of dust, ash, and debris. There were two small tables, one gurney, and a hanging coat rack that had been fashioned into a makeshift IV pole. On the wall was a metal shelf with some medical supplies. There also was one emergency crash box, a defibrillator, and a few tanks of oxygen.

Out of the darkness walked a strong, powerful figure — an EMT police officer. He thanked us for volunteering, showed us all the equipment and asked us to familiarize ourselves with the supplies and surround-

ings. Two other individuals walked into the station and joined us. One was a retired lawyer turned EMT from Pennsylvania. The other was a medical resident. We all sat down, and for the first time I really saw what no photograph, news report, or television footage could ever capture. The scene was so surreal that it caused my heart to die at that moment. All color drained from my face and I lost my breath.

Ground Zero was a craterous void, from which were emanating the flames of hell and the smoke of the consumed. There was a high mountain of concrete, mangled steel, dirt, debris, and rubble. The Twin Towers, once a proud testimonial of humanity’s strength and power, was now the largest gravesite in history. There was no life; only absolute devastation and destruction. I was looking at the modern-day fall of the tower of Babel.

We all sat together, exchanging a somber moment, knowing we were each trying to assimilate the scene in front of us. We were waiting to assist anyone in need of medical care, but there was no one there. Was this our only function? Outside, there were hundreds of people working in a synchronized bucket brigade, frantically trying to rescue the living and uncover the dead. On their hands and knees, they tried to clear and unearth anything that could be brought home to the thousands waiting to either celebrate or mourn.

Digging Through Debris

We got up, knowing our duty was right there in front of us. We joined the mass digging efforts. I remembered as a child climbing a hill in joy and freedom to see what was on top. Now, as an adult, I felt a fervent urgency to climb this hill of tears and dig like I had never done before. On our hands and knees, with our only protective gear the garden gloves we had been given, we all dug in synchronized, purposeful rhythm.

What I uncovered that night were layers of true horror. The ground was very hot and the air was dense with choking fumes. I filled buckets, first with dirt and then with building

debris. Then came signs of what was once a huge, functioning workforce of thousands. There was the occasional business card, parts of a day planner with smeared notes, pieces of a briefcase. These things brought me closer to what I feared the most. Then I found a shoe — and nearby, a foot.

I called out to tell a rescue worker of the grisly remains. He gently took it from me and called for a container. This towering man, rough and filthy, exhibited sensitivity and utmost care. He held the mangled flesh as if it were a newborn baby and placed it carefully in the container. I continued to dig, saying a silent prayer for the unknown man who had just taught me one of the most important lessons a nurse could learn: in life we celebrate, in death we must respect.

I went back to the firehouse and notified the officer it was time for me to go. My brother was ending his shift and I had to get back to the precinct in order to get home. He thanked me and asked if I would be back tomorrow. Without a moment’s hesitation, I said, “Of course.” He smiled and said good-bye.

I walked back to the ferry through the quiet dawn and met Jim at the end of his shift. We held each other. He asked me if I was okay and if this experience was worth it. I replied it was the best and the worst day of my life. He told me he understood.

Back to Firehouse 10

The next morning, my steps now sure and steady, I signed in and hopped on the ferry. On my way, I called a few of my friends on my cell phone to let them know I was going in again. They all offered their support. From them, I regained the strength and compassion needed for the long days and nights ahead.

I met a specialized emergency rescue team on the ferry. We talked and bonded quickly. When the ferry docked, they drove me back to Ground Zero, where I had been the day before. The same team was there, and we gave each other supportive hugs. A few new faces — a new doctor and nurse — were also

present. The doctor told me that this firehouse had been commandeered as the First Command Center Post/Triage Station for Ground Zero. More supplies would be arriving, and he needed the station to be organized for triage. He introduced me to the other personnel, and we began to build the unit again.

Another nurse and I immediately got to work. We had the same ideas about priority and organization. Without warning, a thunderous sound was heard. Screaming and yells urging all to “Run!” were our only warning. We grabbed each other in a buddy system and ran out the back of the fire station and far up the street. We received word that more buildings had partially collapsed, and we had to wait for a signal allowing us to return.

A frantic nurse asked me for my cell phone so she could call her husband to see if he was okay. She let out a gasp and she listened over and over again to a message on her answering machine. It was her husband, reassuring her that he was okay, that he was at another location. Suddenly, he screamed in shock that the building was falling — and the line went dead. We all tried to comfort her without success. She went back to her family to begin a vigil of waiting, like the thousands of others.

Evacuations and Stampedes

Fueled by this experience, I refused to wait any longer to return to the triage station and soon the work was finally completed. We were later told, however, that the whole unit was being moved farther away, and all supplies had to be loaded and taken to the newly designated area. I questioned this move, since this was where we were needed most by hundreds of rescue workers and possible survivors. The doctor could not defend this decision, saying it was what he had been told.

A rescue worker took me aside and held my hand. Calmly he told me that this building could possibly collapse without warning and I would be killed. He pleaded with me to leave. I refused, telling him I would rather die than run away and possibly have a delay in treatment cause someone else's death. At that instant, we felt another tremor and the all-too-familiar yell to evacuate. The wave of people was so intense I had to push myself against a wall to avoid being crushed to death. I held my breath and closed my eyes for a couple of seconds that seemed an eternity. When I opened them again, I saw an abandoned station and the skeletal remains of the rescue medical center we had set up.

A head fire chief came into the building, I told him I was not leaving and I would try to set up the triage with what minimal supplies were left. I asked him if he could clear a larger “runway” for a safe escape if another emergency arose. He agreed, and we were back in business.

My tables were set up according to acuity and priority. Stations were separated according to treatments and function. Shelves were stocked in order of usage. I began to do a policing of the area because garbage was overflowing. Sterility was by no means practical, but neatness brought a better sense of order and protection against biohazard.

Later, to my surprise, the old team came back. The doctor informed me that it had been determined that Firehouse 10 was safe after all and

would remain the First Command Post. We exchanged a smile. He asked me what I had done, and I gave him a full report. He called the team together and told them that since I was the one who had been there from the beginning and had set up the triage system, I would be in charge of all old and new personnel. I briefly went over the set-ups and system of treatment-priority.

Workers at Point of Collapse

We were prepared for what was to be a long night. It started out slow and intermittent. Then it began to increase. Some of the workers were at the point of exhaustion and collapse. The physical, mental, and emotional strain was finally hitting them. I can only compare it to running multiple code teams. They were coming in with shock, dehydration, lacerations, respiratory disorders, asthma, severe eye burns, and irritations from the smoke and chemical exposure. Oxygen was being depleted at an alarming rate, and calls for more care became frantic. They were also calling in from the field to coordinate a team for on-site rescue efforts. People were trying to locate everything from bone cutters to saws at the same time. No matter how insane the situation became, we all pulled together and never missed a beat.

Representatives from the Federal Emergency Management Agency (FEMA) came that evening, and I gave them a report on the supplies and needs of the unit. The team all looked after each other and rotated short 5- to 10-minute breaks. We passed cell phones around to reassure our friends and family that we were fine.

More volunteers came, and I met a wonderful trauma nurse. During one of the influxes of workers needing care, she asked if I was in charge. I gave the briefest summary and told her I would appreciate her guidance and direction. She flew into action. Her swift assessment of the situation, from set-up to treatment, was brilliant. I will always be thankful to her for coming to our assistance.

Dawn approached, and it started to pour. The team left after new volunteers arrived, and four of us headed back to the ferry as

comrades in arms. The rain didn't bother us. It was a welcome relief and a symbolic washing away of the tension. We stopped for a brief picture together, and said our good-byes. I couldn't thank the trauma nurse enough for her invaluable work. She gave me the same compliment. We laughed and finally agreed it was not you or me, but “us.”

Bringing Care to Workers

When I arrived at the ferry the next day, I was honored to find myself with a large group of dedicated professionals from the military, emergency rescue, and medical professions. The ferry was delayed because President Bush was arriving in the city. We were locked in together, anticipating making our rescue efforts this day better than the day before.

Everything happens for a reason, and this was no exception. It was a very cold day, and a man literally took the shirt off of his back to help me stay warm. Another man saw that I had an inadequate mask and

“Screaming and yells urging all to ‘Run!’ were our only warning . . . more buildings had partially collapsed.”

gave me his, sacrificing his own needs. I met another nurse who needed to set up a relief station on the other side of the ferry. We discussed our own experiences and coordinated the Red Cross workers to get her the necessary supplies.

Lastly, I met a group of rescue workers who specialized in excavation. They were going to Ground Zero to uncover survivors and bodies. I realized that I had organized supplies for one of the men during the previous days at Ground Zero. I hugged him in appreciation for his team's heroism. He was grateful for our efforts as well. He lifted me up on their transport vehicle and I rode with his team through the newly established checkpoints, back to Ground Zero.

My home base at Firehouse 10 was better than before. There were more supplies and new faces to welcome. Another restructuring was ordered because the station was to be divided again to make room for planning and coordination of rescue efforts by a more specialized group of rescue and fire department personnel. A new team of nurses arrived. The camaraderie was electric and fueled us throughout the night.

The only problem was that the rescue workers were not coming in for medical treatment and respite time. When the needs and organization of the triage unit were completed, we reasoned that if these men weren't going to come us, we were going to them. We began to go out to the site and into the crowd, delivering protective gear, food, water, and medical care. Treatments ranged from eye-washes and drops, Tylenol®, Band-Aids®, antibiotic creams and dressings. We took care of their dogs and set up a station for the animals to sleep, eat, and get their poor, torn feet bandaged. Finally, we talked to the workers, giving them emotional support. We offered our ears to listen, our shoulders to lean on, and, if just for a few moments, a look of understanding to communicate that we were there for them.

As I said good-bye that night, I sensed that this would be my last walk back. I walked those miles slowly, making sure I felt every step. I got on the ferry and went right to the open front area, next to the water. I felt the cold, crisp wind and looked into the pre-dawn sky. The stars were still and brilliant.

I could hear my own heart beating louder and a calling in the air. I looked around and found the meaning of the call. Lady Liberty stood before me, alone, proud, and strong. Her words rang out soft as a whisper, but loud and clear in my soul. She cared for the tired, the poor, the unwanted. As the tears welled up in my eyes, I wanted to remember this moment forever. Lady Liberty and I shared something very special that night. She created a new land of democracy and I had played a small part in helping her community start to heal and come back to life.

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Recognition must be given to some very special individuals. Without them and their supportive words cheering me on, I might not have had the strength, compassion and composure for the long days and nights I spent at Ground Zero. I wish to thank Donna Madonia, my dear and best friend of many years, who kept a lifeline open to my family and my heart in order to stay focused and strong; Wendy Westcott, a companion and soul sister who knew the complexity of purpose and strength to give to others when we can't even give to ourselves; Karen Glasgow, a new-found friend and fellow student who shared a special connection, not only professionally but personally; to my sister-in-law, Diana — we are of one blood and you are a true sister. I thank you for caring for me when I couldn't care for myself.

Through the Eyes of a New Yorker

Lucille Yip, RN

September 11, 2001

I am surprised when I wake up at 3 a.m., since I had been so tired after coming home from a late dinner. I don't feel right. Somehow I feel the need to go to my living room and look at the New York skyline. It is a spectacular view, full of lights and beautiful skyscrapers. I stand at the window to absorb the peaceful beauty of the city. I return to my bedroom at 5:30 a.m.

A few hours later, I wake up to a sound of an explosion. My apartment is located at the top of a 44-floor high-rise, facing what used to be the most beautiful skyline in the world. I turn on the TV and see the news. Hoping this is a dream, I run out to my living room window in horror and shock. The World Trade Center that I had grown up with is burning out of control.

After the second plane crashes, I call my sister, who works at the Federal building [six blocks from the World Trade Center]. "I'm leaving," she says, and I don't hear from her for six hours after that. I later learn she was on the train when the power shut down and

smoke began to enter the car, but she was able to get home safely.

I witness the collapse of Tower 1 and then Tower 2. They both fall like a deck of cards. My "backyard" now resembles a war zone. Shortly after the collapse, I am told to evacuate the building. Hundreds of people from the Wall Street area are walking through my neighborhood in Chinatown. People are painted with thick, white soot. Cell phones are down and long lines begin to form at the payphones. There are no subways, no buses. The sounds of sirens fill the air and New Yorkers gather around car radios to listen to the news. It is total chaos.

I need to get to the ER [at St. Vincents Catholic Medical Center] and help, but I have no way of getting there. I decide to hitchhike, something I never would have thought about doing in New York before today. I find a sanitation worker who is willing to take me.

I arrive in the ER to what appears to be controlled chaos. I am assigned to triage patients. I see patients with severe burns, smoke inhalation, and open fractures. The ER is pre-

pared for any victims that may have survived. The trauma team, anesthesia team, nurses and doctors are situated inside and outside. Stretchers, wheelchairs, and oxygen tanks line the sidewalks. The news media have stationed their cameras across the street, hoping to catch a glimpse of any survivors.

The ER is overstaffed because volunteer nurses and doctors have come in from Long Island, Queens, Manhattan, and as far away as Maryland. Doctors and nurses I have not seen in years come to the ER, hoping to help. The camaraderie is uplifting.

The staff is informed that we can't leave the hospital until further notice. We don't know if the night staff will be able to enter the city. I am physically and emotionally tired. Late in the afternoon, Starbucks donates fresh coffee and water. It sure hits the spot. The Starbucks on Greenwich Avenue has closed its doors to the public in order to cater to our needs. The local restaurants donate sandwiches, hot food, and gallons of water. Residents from Greenwich Village came in, wanting to help and donate blood. I am moved to

Lucille Yip worked as an emergency room nurse at St. Vincents Catholic Medical Center in Manhattan at the time of the September 11 attacks.

*“I am consumed by the silence, smoke, and emptiness
in my neighborhood. Is this my New York?”*

hear that an elderly woman brought over one plate of spaghetti for anyone who might be hungry. I am so touched to see the outpouring of support from my fellow New Yorkers.

The ER is busy, but also painfully quiet. We do not receive any survivors from the collapse. The silence after the initial rush of patients is deafening. The night shift arrives, and the staff is able to leave. I have to ask a police officer for a lift home, since there is no public transportation south of 14th Street. I manage to squeeze into a police van filled with officers and they drop me off at Varick and Canal Streets.

As I walk through the streets of lower Manhattan, I feel like someone had sucked my spirit out of me and ripped it into pieces. The streets are empty, there are barricades on every block, stores and restaurants are closed, police and state troopers are standing on every corner, and people are wearing face masks. I am consumed by the silence, smoke, and emptiness in my neighborhood. Is this my New York?

A passerby looks at me. We share the same pain but say nothing. Near my apartment, I am stopped by a police officer standing in front of several barricades. “Where are you going?” he asks. I show him my ID and tell him I’m going home. He allows me to go through the barricades and comments, “Get some rest. We’re in this together.”

My husband has not been able to get home. The apartment smells of smoke. I turn on my TV for the latest news. My neighbor knocks on my door to see if I’m all right. She offers some of her dinner to me, knowing that I haven’t eaten anything. I’m touched by her kindness.

I can’t sleep and watch the news until 2 a.m. The sound of the explosion still echoes in my head. I need to rest — tomorrow will be another long day.

September 12, 2001

I wake up after sleeping only three hours. The phone lines are still down and I am unable to reach my husband. I know he is safe at his restaurant and hope to call him later.

My street is blocked off to all traffic except official cars. I will have to hitchhike to work again. I flag down a patrol car, which drops me off in front of the ER. The street has been blocked off to pedestrians, except hospital personnel. There is a crowd of reporters, cameras, and onlookers across the street.

I am assigned to triage again, which means I have to see every patient who enters the ER. A 38-year-old fireman comes in with a crushing chest injury caused by falling debris. Surprisingly, he is sitting up, talking, and coherent. Despite his ashen color and his concave chest, in my heart I hope he will survive his injuries. In my head I know that his chances of surviving are slim. Nevertheless, I am shocked when I’m told later that he died on the operating table.

Many firefighters come into the ER with breathing problems secondary to smoke inhalation, burns to the eyes, open skull fractures, and femur fractures. I should be called the “traffic nurse,” since I was directing patients to different parts of the ER and hospital.

I also am the first nurse to see families, friends, and rescue workers looking for information about their loved ones. They come with pictures and stories about their friends or family members. I have to turn away dozens of them. My response is the same for many days: “No, he’s not here. We have no Jane or John Does. All patients have been accounted for.” It is heart-wrenching to say this over and over.

A 50-ish Hispanic woman asks me if her husband has come into our ER. My response: “No, he’s not here.” She holds back her tears when I say, “I’m sorry.” She tells me that she worked in Tower 1. After the initial crash, she received a call from her husband who worked in Tower 2. She was able to get out safely but her husband was missing. “He called me to see if I was okay and I told him I was leaving the building. I haven’t heard from him since the call.” I put my arm around her as she breaks down and cries. She thanks me and walks away with a look of resignation in her eyes.

My co-worker shares a story about her cousin’s husband who is missing. The wife recently has been diagnosed with ovarian

cancer and has only six months to live. Her husband took care of her and the two children. Now he is gone and soon his wife will leave this world. The children will become orphans. I am speechless as she shares this story with me.

An unbelievable number of volunteers gather outside the ER. There are tables full of donated food and beverages. Kathleen Turner is handing out couscous to the ER staff. A colleague is upset when I ask him, “Who the heck is Kathleen Turner?” An actress from the show “Third Watch” also is helping at the table. It’s great to see people from all walks of life helping. We even have massage therapists giving the staff free massages in the Head Nurse’s office. Incredible — who says New Yorkers aren’t giving?

The shift is almost over and night has turned into day on 7th Avenue as huge spotlights light up the street. I chat with a police officer who has visited the disaster site. He tells me that most of the bodies have been decapitated and that the Medical Examiners are unable to determine the sex or race of the bodies. Body parts are scattered everywhere. I ask him how he’s holding up. “I haven’t seen my kids yet,” he says. “I’m exhausted. It’s just unbelievable. I don’t know how to get over this.”

The shift is over and I have to hitchhike again. A volunteer drives nurses and doctors downtown in his SUV. We are detoured to the West Side Highway, where crowds are cheering for rescue workers, NYPD, and us! I’m surprised that people would stand along the highway, holding up flags and posters saying “Thank You!” “We love the NYPD and FDNY, you are our heroes!” It is uplifting to see after a long day at the ER.

I arrive home after passing through my neighborhood checkpoint. I’m happy and relieved to see my husband home. He had parked his car on Irving Place and biked the rest of the way home, since public traffic remains closed in our neighborhood.

He’s on the phone, so I go into the bathroom, sit on the side of the tub, and cry. It’s my first good cry since the disaster. I cry for

the dozens of family members I had to turn away. I cry for the innocent lives that were lost. I cry for my colleague's cousin, the firefighters and the police officers who died. I cry for the total devastation. The tears won't stop, and nothing eases the pain.

I cry out, "Why? Why did God allow this to happen? There are not enough lessons that we can learn to make up for this. Why did so many have to die? I hate this! Thank God we don't have children. What would I say?" My husband allows me to scream and cry without judgment. He listens and comforts me during this horrific time. I love him more than I did 11 years ago when I said, "I do."

September 13, 2001

I have slept for three hours. I have no desire to eat or sleep. I look out of my living room window and see the smoke from the site. I turn on the TV and listen to the stories about the missing and the dead. These were people who had families. I hear stories about the firefighters that ran into the World Trade Center while others ran away. I hear about the parking lots in Long Island that remain full because the car owners are missing or dead. I hear about the last calls made by the passengers on the plane to their loved ones. I am overcome with emotion. I call the head nurse in the ER and ask her if I can come in an hour later so I can "get myself together."

After I get to the hospital, I'm assigned to Room 5, the critical part of the ER. We are ready and prepared for any survivors. Once again, the silence is painful. We receive no survivors, not one. The reporters and cameras are still present on 7th Avenue, also waiting for a glimpse of hope.

This tragedy brings out the best and worst in New Yorkers. More good than bad, thank goodness. I try to focus on the good, but today I see the darker side of people in the ER.

I care for a 42-year-old man who pretended to be a fireman. He had been trapped under two large steel beams at the site while trying to help. Unfortunately, he had actually been helping himself. He is intoxicated, but coherent enough to provide information.

We undress him, despite his objections, in order to examine his injuries. A nurse technician begins to label and bag his belongings and finds several wet and muddy rolls of money. My stomach turns as we uncover new watches, earrings, a child's tiara, family photos, and an address book. We realize that this patient has been looting from the stores and worse, stealing from the dead. There are 50 personal photos in his pocket. When we question him about his belongings, he says, "Oh, the photos are from family members. The watches? Well, I went shopping down the block."

Does he really think we're that stupid? Families and friends are not supplying us with original photos; only copies with names and addresses. I am disgusted. I ask another nurse to draw the patient's blood and give him a tetanus shot while I document on the chart.

I know this sounds wrong, but I can't bear to heal someone who was stealing from the dead. It is the first time in my ten years of nursing that I am unable to take care of a patient, but I'm not ashamed. Over the

years, I've taken care of patients that were high on drugs, cursed me, punched me, and spat on me. I never hesitated to care for them because I never took their actions personally. This man is the one patient I do not want to nurse back to health, because I *do* take his unspeakable actions personally. I need to remove myself from him.

September 14, 2001

I have a difficult time catching a ride to work. I finally flag down a couple of construction guys and get a lift in their pickup truck. The truck is full of equipment that has to be removed to make room for me. I sit between two big, burly, sweaty construction workers that have just returned from the site. One of the workers tells me he fought in Vietnam and thought he had seen everything until he visited the site. "I can't believe it. Ugh, it's just incredible. Vietnam was nothing compared to the World Trade." The rest of the ride is quiet. There is nothing we can say to wake us up from this nightmare.

I arrive in the ER and see a K-9 dog sleeping there. The night nurse tells me the dog is being treated for dehydration after working a 12-hour shift. The dog sniffed out 10 buried police officers . . . all of them dead.

Governor Pataki is expected to visit the hospital again. Since the disaster, Mayor Guiliani, Governor Pataki, Cardinal Egan, and the State Health Commissioner have visited the ER. They thanked the injured firefighters and police officers. I expect the Governor is just going to shake a few hands and leave. I'm touched when he gives a speech to the ER staff, thanking us for our help and efforts. His speech is heart-felt, sincere, unscripted, and encouraging.

The ER is painfully quiet. My shift is almost over when a young woman comes in with a detective. The detective sits down in the triage chair while she stands silently. He asks me, "Did you have any John Does since the disaster?" My response is the same as it has been for the past four days: "No, every patient has been identified and accounted for."

The detective isn't satisfied with my answer and becomes more persistent. "I've been a detective for 28 years. You can't tell me that you don't have any John Does. Every ER we visited told me that they have no John Does. Did every patient have ID?"

"Yes," I reply.

"That's impossible!" he says.

I tell him that every patient was coherent enough to provide information. The detective and the young woman remain quiet in disbelief. I can feel their frustration. I turn to the young woman, who looks pale and tired,

and ask her, "Who is it that you are looking for?"

"My brother," she replies. "He was in the World Trade Center during the collapse and I haven't heard from him." I have never felt so helpless. For ten years, I have been able to provide comfort, answers, and healing to the sick and less fortunate. I'm blessed with the gift and opportunity to be in a profession that can directly touch another human being. But now I feel powerless. Nursing school had not prepared me for this. As the young woman stands silently, I give her a hug and say, "I'm so sorry." I feel empty and my spirit is dry.

"A K-9 dog is sleeping in the ER after working a 12-hour shift. The dog is being treated for dehydration. He sniffed out 10 buried police officers . . . all of them dead."

September 15, 2001

It's 2:30 a.m. and yes, I am still wide awake. I'm trying to unwind from what has been the most moving, unbelievable, horrific day of my 34 years on earth. I have just returned from the disaster site.

I had completed my fourth straight day in the ER at 9 p.m. Earlier in the evening, my supervisor returned from a visit to the site and had described the magnitude of the devastation. I and many of the ER nurses felt the need to see the site for ourselves.

Since then, many people have asked me why I would even think about visiting such a site. I don't really have an answer for them. I felt like this was a dream and I needed to make this surreal experience real. I had been cooped up in the ER for days. The ER was full of "big-wig" administrators, politicians, federal agents, and reporters. I felt like I was in Noah's Ark, with no windows to see what was going on outside. We were confined to this small place, taking care of the rescue workers and sending them back out.

A paramedic told me I could see the site since I worked in the ER and I was still in my scrubs. I convinced a police officer to drive me and hopped into his car along with three other officers. One of them escorted me to the area as the others waited in the car. I was familiar with the area since I shopped there quite often, but this time I had to ask, "Where are we?"

He said, "We're standing across the street from what used to be the World Trade Center. Are you going to be okay?"

I had to hold onto his arm as I replied, "Yeah, I'll be fine." Disbelieving, horrified, shaken, and nauseated are only a few words to describe how I felt. What the public saw on TV *cannot* compare to what I saw . . . unless you multiply it by 100. I saw piles of rubble, huge steel beams, shattered windows, muddy white soot, and a huge crane that held what was left of the Tower's entrance.

As I stood across the street, I was in shock. I looked up to the sky, which seemed so naked without the Towers. An F-16 fighter plane flew through the clouds of smoke. I didn't cry. I didn't search for answers. I couldn't feel my body. I was completely numb. A rescue worker asked me if I was okay. I didn't respond. He commented, "Incredible, isn't it? They wanted to get us and they sure did."

My feet were full of mud and the air seemed much warmer than it did when I left the ER. Initially I was glad, because I hadn't worn enough. Then I realized the warmth was from the fire that was still burning. I began to walk through the site. It looked like a winter land of ashes, with the buildings quiet, dark, and empty. The lobbies were painted with thick, white soot and the sounds of cranes and trucks filled the smoky air.

I watched the National Guard marching in unison down Broadway saying, "Left, right, left, right." Huge spotlights turned night into day. There were volunteers, food, water, donated shirts printed "United We Stand," the American flag, weary rescue workers, tires that had been blown off . . . and the pervasive smell of body parts.

I began to cry when another volunteer asked me if I was all right. He was a seminary student who had driven all the way from Nebraska when

he heard the news. He led me into the beautiful chapel on Broadway that miraculously was left unharmed by the blast. I sat on the pew weeping.

I wept for the 38-year-old fire fighter with the crush injury to his chest. I wept for the dozens of family and friends that had come to me, hoping to find their loved ones. "I'm sorry, he's not on our list." I can't remember how many times I said this, and it broke my spirit. I wept for my sister, Anna, who thought she was going to die when the train stopped and smoke started to fill the car. I wept for the dead.

The volunteer and I hugged. He gave me his necklace that had a beautifully engraved, wooden cross attached to it. "Take care, Lucille, and God bless you," he said.

I decided to walk home. I received many comments along the way from officers, sanitation workers, and rescue workers. "Hang in there." "Thank you." "Do you need a lift?" "You look exhausted, get some rest." I walked down the street in my hospital booties and face mask, with my red, white, and blue ribbon pinned proudly onto my scrub top. I finally reached my apartment and sobbed again. I didn't even put my bag down when I just lost it. This tragedy is the pure essence of evil.

As I write in my journal, I hear F-16s circling the area. I keep my blinds closed. I need to rest. I need to get away. We have decided to go to New Hampshire for two days to visit my nieces before returning to the war zone. I'm hoping to volunteer at the site when I return. They need nurses to irrigate eyes, provide breathing treatments, and care for the rescue workers. It is the only way that I can grieve and heal . . . by healing those who are weak and heavy-laden.

As we leave the city, we see the American flag on car windows, antennas, and storefront windows. New Yorkers are painfully honest, down-to-earth, energetic, always in a rush . . . and kind. Today, the people of New York are moving at a slower pace. No longer do you hear cars honking their horns and everyone seems much kinder. I'm proud to be a New Yorker.

*"The only way
that I can heal...
is by healing
those who
are weak and
heavy-laden."*

September 16, 2001

My husband and I sleep through the night, the first time in days. The air in New Hampshire is cold, crisp, and clean. It's quiet. I don't hear sirens, helicopters, and trucks. I don't see the smoke or the bright lights. I am enjoying the peacefulness.

My young niece asks if we would like to attend church with them. I really don't want to go because I am too angry at God to be in His house. I don't share my thoughts with the others. The congregation sings hymns of praise as I stand silently with my head down. I don't want to give thanks. I am in too much pain, too upset and confused with God. As the congregation begins to sing "Holy, Holy," I begin to sob uncontrollably. My shoulders are shaking and I can't catch my breath. My husband puts his arm around me and I finally regain my composure.

Looking back, our visit to the church was healing and a blessing in disguise. I haven't cried uncontrollably since that day. God has comforted me in spite of my attitude.

September 18, 2001

The park at 14th Street and Union Square has become a gathering place for New Yorkers in mourning. Hundreds of people gather there to view the pictures of the missing. Candles, flowers, and cards from children surround the park. A local church has set up a microphone in the middle of the park to allow people to share stories and sing hymns. I sit down to hear how they will try to make sense of this tragedy. They don't. Instead, they ask us to join in while they sing "Amazing Grace." I don't sing. I just sit and absorb the incredible spirit that I feel from my fellow New Yorkers. I make eye contact with others and can't believe how we have all come together to mourn. All different races, religions, and backgrounds are united in this time of sorrow and pain.

September 27, 2001

The Mayor announces that it will take one year to remove the steel, rubble, and human remains from the disaster site. Only 10% of the rubble has been removed in 2½ weeks. I wonder, "Does this mean the smoke will continue to fill the air? Does this mean the sounds of the trucks and helicopters will continue to invade my home? Does this mean the new view from my apartment will be of the huge spotlights lighting up the world's largest human gravesite?"

There *must* be a reason. I don't know if there could be one or several answers to satisfy me. Perhaps the reminders *should* remain for a year . . . or more. Maybe we, *I*, need to be reminded that life is beautiful and fragile. Maybe *I* need to be reminded that materialism is not important. How many purses, shoes, and cars do I really need?

I have never been a person who takes life for granted. I have always been thankful for each day given to me. During my 10 years of nursing, I have seen, smelled, heard, and touched death.

I saw the eyes of death when I cared for a young male with full-blown AIDS. He said he felt like he was going to die and he was trying to get off the stretcher. The staff thought he was confused, but I knew he didn't want to give into death by lying on the stretcher. He died a few hours later. I shall never forget the *look* in his eyes as he took his last breath.

I have smelled death in a young patient with end-stage breast cancer. I shall never forget the *smell* of her body, dying right before my eyes.

I have heard the sounds of death. I remember working a couple of days before Thanksgiving. A husband rushed his wife into the ER after she became unresponsive in the car. She was on her way to her next chemo treatment when she stopped breathing. After working on her for 30 minutes, the doctor pronounced her. The husband let out a cry that silenced the entire ER. I shall never forget *hearing* his cry of pain.

So, I have seen, smelled, and heard the sounds of death. I have touched the hands of the dying. What more do I need to learn? Obviously, I need to learn more. Perhaps, even I have become too complacent with life.

Today, I have the pleasure of speaking with Mr. Orin Smith, the CEO of Starbucks. I wrote a letter of appreciation to him for his company's generosity during the disaster and included a couple of excerpts from my journal. I am surprised when he tells me how my journal moved him in a way that the newspapers and TV reports had not. He asks to print my letter on his Web site. I am happy to have the opportunity to thank him on the phone. He is so soft-spoken, gracious, and sensitive. I'm writing this journal for myself. It's honest, sincere, and raw in its emotions. I'm not looking for the praises of others. The journal is an outlet for the emotions I have about the attack.

The Mayor has urged New Yorkers to go out and enjoy the city. He says that we should "get back to our normal lives." So I decide to heed his call and go out. The Broadway actors from "Kiss Me Kate" donated tickets to the ER staff. It's the first time I have gone out and enjoyed the city since the attack.

It is a beautiful night in the city. The air is crisp and clean. It feels good to inhale air that isn't smoky. As I wait for my friend at 45th Street and 8th Avenue, I hear a conversation between a scruffy-looking male and a young female. The guy is telling the woman how good his stuff is — "Try it." I am witnessing a drug deal in the heart of the city. It's nice to know that some people have gone back to their normal lives. Mayor Giuliani would be proud.

September 30, 2001

The head nurse gives each nurse a copy of a letter written by elementary students from Dallas, Texas. Their words aren't fancy, but they bring tears to my eyes.

Dear Hospital Workers,

I am just saying thank you for helping all of the victims in the awful terrorist[sic] attack. Without all of you, some of our loved ones would have died. Thank you for trying your best and working many hours. You have been wonderful. The whole country thanks you.

Sincerely,

A.S., McCulloch Intermediate
School, Dallas, TX

The ER resembles a florist shop as we receive flowers and baskets from hospitals, schools, and well-wishers from across the country. I was deeply moved when three nurses from Alabama flew to New York and personally dropped off a huge basket full of homemade baked goods. They wanted to take a picture with us for their own keepsake.

Letters and cards cover the walls of the entire ER and somehow cover some of the pain. The ER begins to feel "normal" again — no more cameras, reporters, administrators, politicians, federal agents, and extra staffing. The "frequent fliers" of the ER have returned. Our weekly alcoholics and drug users have come back to St. Vincents. Welcome home. I return to my old routine in the ER as I take care of patients who are "high as a kite" or "drunk as a skunk."

Final Entry

So what are the lessons that I am to learn from these senseless and unspeakable acts? What is my purpose, *now*? Who am I, *now*? I am a child of God, whose spirit is slowly healing. I am a wife to a wonderful husband. I am a daughter of Chinese immigrants, who came to the United States because they wanted a better life for me. I am a woman who was born and raised in a country that provided me with the freedom to learn, speak, and live. I am a nurse, a healer to those that are sick. I am blessed with the gift of comforting the sick and providing strength to the weary. I am a loyal friend, always ready and willing to go the extra mile.

Since September 11, I have become a different person. I am more introspective. I am reminded that my life was *never* in my hands to control, but in God's hands. I am reminded that we are not living on earth to collect our next paycheck, or work 9 to 5, or to live a life without any regard for our fellow man.

My prayer and hope is that my life will uplift, strengthen, inspire, and encourage those I meet. May God bless New Yorkers and all Americans.

WHAT'S NEW IN THE

Healthcare Disparities

Williams, D. R. (2002). Racial/ethnic variations in women's health: The social embeddedness of health. *American Journal of Public Health, 92*(4), 588-597.

This article provides an excellent overview of the health disparities of U.S. women. The differences in morbidity and mortality among racial/ethnic groups underscore the challenges of closing the gap for women in health status and health outcomes. A growing body of research focuses on the relationship of socioeconomic status and health. For example, white women who did not graduate high school have a lower infant mortality rate than black college graduates. Medical care provides a limited contribution to the differences in health among the racial/ethnic groups. However, understanding these disparities requires more attention to factors that are typically measured at the level of the individual. The linkages among physiological mechanisms and social exposures are largely unexplored. With the projected changes in the racial/ethnic population of the U.S. in the next decades, the research to explore the answers to numerous questions is urgently needed.

Flaskerud, J.H., Lesser, J., Dixon, E., Anderson, N., Conde, F., Kim, S., Koniak-Griffin, D., Strehlow, A., Tullman, D., & Verzemnieks, I. (2002). Disparities among vulnerable populations: Evolution of knowledge over five decades in *Nursing Research* publications. *Nursing Research, 51*(2), 74-85.

This paper reviews the contributions that articles published in *Nursing Research* have made to the body of knowledge about health disparities in vulnerable groups. Using a more specific set of criteria than that used by Drevdahl, Taylor, and Phillips (2001), 79 research reports, briefs, and methodology articles published between 1952 and 2000 were identified.

The 79 articles meeting the criteria of presenting tested knowledge are summarized chronologically in a table that includes information about the population and the health disparity(s) studied, and the relative risk(s) identified. The number of published reports addressing health disparities increased over the period studied. The authors explore social, political, and economic variables that may have influenced research conducted during each decade.

The authors conclude that articles published in *Nursing Research* have made a substantial contribution to the dissemination of tested knowledge about the health disparities in vulnerable populations. They build a case for more community-based intervention research and the use of methods that involve participants in the research process.

Nursing Practice

Earl, M.L., Jackson, M.M., & Rickman, L.S. (2001). Original research: Improved rates of compliance with hand antisepsis guidelines: A three-phase study [Electronic version]. *American Journal of Nursing, 101*(3), 26.

Even though it is established fact that hand antisepsis is the best defense against nosocomial infection, health care workers frequently neglect to wash with soap and water when indicated. Inconvenience and lack of time are reported reasons for non-compliance. Earl and colleagues conducted a study to determine if a quicker and more con-

venient process of hand washing would increase compliance. This was an observational study, which took place in two hospital intensive care units. After establishing baseline hand washing behavior, healthcare workers on the units were given the option of using a hand-detergering, rinse-free, alcohol-based gel. Dispensers of this gel were installed inside and outside patient rooms. Use of this innovation was evaluated at 2 to 4 weeks and at 10 to 14 weeks post installation. At the end of the trial, hand-washing behavior had increased to 43.9% above the baseline rate.

Ozurec, L.C., Hoover, P.M. & Fields, J. (2002). Acknowledging unexplained fatigue of tired women. *Image: Journal of Nursing Scholarship, 34*(1), 41-45.

The purpose of this study was to measure various indicators of fatigue and included depression, sense of powerlessness and body aches.

In this descriptive, comparative research, the investigators compared two groups of women. One group (n=20) reported fatigue, while the other group (n=20) did not. All of the study participants were biochemically normal women. The groups did not differ in ethnicity, mean weight, and number of medications taken, but the participants in the asymptomatic group were younger. The overall sample was generally healthy, nonpregnant, premenopausal, and at least 18 years old.

The women who reported fatigue differed from those who did not and demonstrated a significant correlation between fatigue and depression and a significant negative correlation between depression and power. Body aches were not significantly different between the two groups.

These findings indicate the importance of acknowledging and managing women's reports of fatigue, depression, and sense of powerlessness. Additional research into these variables is necessary to further explain their interaction in women.

Ray, S. (2001). Male survivors' perspectives of incest/sexual abuse. *Perspectives in Psychiatric Care. Vol. 37* (2), April-June 2001, p. 49-59.

In the wake of recent disclosures of sexual abuse within the Catholic Church, nurses should be acutely aware of the sequelae of such childhood traumas. Data for this study comprised The Incest Questionnaire instrument and interviews with 25 adult male survivors of incest or sexual abuse by family or non-family, trusted adults. Subjects were asked to describe in their own words the long-term effects of the abuse. Responses were grouped into eight areas: social, psychological/emotional, physical, sexual, familial, sense of self, relationships with men, and relationships with women. The abuse affected all eight areas of functioning and included isolation, anger, depression/suicidal feelings, development of addictions, damaged sense of self, and relationships with men and women.

Participants sought therapy for suicidal ideation and depression, and many had histories of addictions and sexual difficulties. The author suggests that assessment of males with physical or emotional problems include sexual history and that appropriate interventions could help prevent or minimize after-effects.

Flynn, L., & Aiken, L. H. (2002). Does international nurse recruitment influence practice values in U.S. hospitals? *Journal of Nursing Scholarship, 34*(1), 67-73.

This article reports on a secondary analysis of survey data with a sample of 799 nurses, 547 of who were born in the U.S. and 252 born in 34 other countries. No significant differences were found between

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U.S. and foreign-born nurses in the overall degree to which they valued a professional practice environment as important to their job satisfaction. Both groups placed value on exerting control over the practice environment, establishing collaborative and collegial relationships with physicians, and autonomy in nursing practice. International nurses from collectivistic cultures placed higher value on collectivism and ambiguity-reduction strategies than did U.S. nurses. No significant differences between the two groups of nurses were found about the importance of hierarchy. The authors report that the failure to find a difference on this factor may be related to the weakness in the measure used for this item. The findings of this study indicate that U.S. and international nurses may share a set of core nursing values that are described in the magnet hospital literature.

Nursing Image

Powers, P. (2001). The image of nursing in hospital promotional materials: A discourse analysis. *Scholarly Inquiry for Nursing Practice*. Vol. 15(2), 91-108.

People interested in the issues raised by the image of nursing in the media and public relations, and those interested in the philosophical method of study called discourse analysis, may find this study helpful. Texts and pictures taken from a sample of public relations materials from 331 randomly sampled hospitals of over 100 beds in the U.S. were analyzed in order to identify visibility of nurses and nursing and the power relations suggested by this data. Discourse analysis is clearly outlined and describes a relatively new and interesting methodology. The author concluded: 1) Nursing is not invisible in this material; however, nurses are more visible the closer their duties are to medicine or administration; 2) The nursing voice is strong in the materials because consumers believe that the quality of the hospital and the quality of nursing care are related; 3) Nursing benefits from marketing discourse as long as nursing is a consumer concern; 4) The discourse of advanced practice nursing is being co-opted into the discourse of medicine.

Nursing Education

Goudreau, K.A. & Chasens, E.R. (2002). Negligence in nursing education, *Nurse Educator*, 27(1), 42-46.

The authors describe legal cases involving negligence in education, and discuss ways to reduce the risk of injury to students and related litigation. Although students' own contributions to their harm, including willing assumption of risk, are frequent defenses, the courts have determined that educators have a responsibility to determine foreseeable risks and to instruct students on how to maintain safety. Negligence is generally defined as the failure to act in a "reasonably prudent and careful way" that subsequently becomes the proximate cause of a foreseeable injury. Educational negligence is another kind of negligence where students may claim that they have been harmed if they graduate from a nursing program that has left them unprepared for practice. Nurse educators need to understand what constitutes both kinds of negligence so that they can protect students from harm, and themselves and their employers from legal claims. Courts have asserted that educators have a duty to their students that is greater than they would have to the general public because of the special nature of the teacher-student relationship. However, students must

learn to ask for help and not allow themselves to be placed in dangerous situations. Educators must take time for frank discussions about actual and potential risks, and give students time to appraise for themselves whether they are personally willing to take the risks involved in a clinical profession. Subsequently, there must be a low enough student-teacher ratio in the clinical setting that instructors can give close supervision.

Nursing Research

Kalb, P.E. & Koehler, K.G. (2002). Legal issues in scientific research, *JAMA*, 287 (1), 85-91.

This article describes how the federal False Claim Act (FCA) allows the government to recover treble damages, plus substantial penalties, from persons who knowingly submit false claims to the government while engaged in research activities. In recent years, regulatory and law enforcement authorities responsible for combating fraud and abuse have focused more attention on the scientific research process, particularly reimbursement mechanisms. The article describes how the False Claim Act has been used to achieve multi-million dollar settlements with research institutions. It includes examples of temporary suspension of research activities at a number of prominent institutions, and the investigation of illegal "inducements" provided by manufacturers to investigators, and by research institutions to patients. The FCA is primarily enforced by the Department of Justice, but private whistle-blowers may bring suit on behalf of the United States and, if successful, may collect a bounty of up to 30% of the government's recovery. When whistleblowers bring suit, they file their allegations secretly, and the Justice Department then has an opportunity to investigate and determine whether to intervene and assume responsibility for the lawsuit. Whistleblowers have been a significant source of false claims against research institutions in recent years. Because employers can be held liable for the actions of individual employees, research institutions may be held liable for the misuse of federal monies or false statements made by individual investigators or administrators, even when senior level institutional officials are unaware of the misconduct.

Obesity

Young, L. R. & Nestle, M. (2002). The contribution of expanding portion sizes to the U.S. obesity epidemic. *American Journal of Public Health*, 92(2), 246-249.

This article describes the changes in food portions since the 1970s. Marketplace food portions now exceed federal standards by as much as 700% in the cookie category, 480% for cooked pasta, 333% for muffins, 224% for steaks, and 195% for bagels. Other categories of food portions have increased from 2 to 5 times the original portion sizes. The authors raise concern because of the increase in calories that contributes to obesity in the U.S. population. An example is the 7-Eleven Double Gulp, a 64 ounce soda, which contains almost 800 calories, almost 10 times the size of an original Coca-Cola and calorically equivalent to more than one third of the energy requirement of large segments of the population. The authors point out the need for greater attention to food portion size as a factor in weight management. They also advocate efforts to explain the relationship of portion size to caloric intake, weight gain, and health.

Volunteering with the Red Cross Family Emergency Relief Services

Carol Noll Hoskins, PhD, RN, FAAN

As reporter John O'Neil so aptly stated, "After an extraordinary string of fat years and rapid growth, the nation's charities are facing the toughest times and toughest choices in decades. The shock of the September 11 terrorist attacks, the flood of money pouring into relief efforts, the sudden contraction of the nation's economy, the slump on Wall Street and the recent disruptions in the mail have nonprofit groups rushing to adjust during what is traditionally the busiest funding-raising period of the year." (*The New York Times*, 2001).

Certainly, September 11th was, and is, a date indelibly etched in the mind and memory of every American. For each individual, a different constellation of intense emotions and experiences surface when a report of an earthquake, a volcanic eruption, or some other

disaster is reported in the news. And yet, who across the country would ever have imagined that an event of such horror could occur? America has always been viewed as relatively safe and sophisticated in its ability to protect itself through security organizations that were considered to be always vigilant and well informed.

As millions stared at a television screen with disbelief, either at the time the tragedy occurred, or as it was played and re-played, shock, disbelief, and grief overcame most of us. The tears of horror and fear couldn't be avoided. How could this be happening? And how could those who had escaped find the energy to mobilize? Conversely, how could the less fortunate who were trapped, leap from hundreds of feet in a desperate but futile attempt to escape certain death? As the hours

turned into days, how could those who lost persons who were integral parts of their lives cope with the unbearable grief?

As each of us experienced a range of such feelings, there was an unavoidable and profound effect that could not be escaped and would never go away. Every American had to explore how he or she could process, absorb, and deal with the events of September 11th. While there is no doubt of the enormous impact on all Americans, it is quite likely it was most profound for New Yorkers. Every day brought new reminders as new events related to September 11th unfolded, immobilizing some, gripping others with an immediate, compulsive need to help, to rescue, to save, to drive to a state of exhaustion searching for, and hoping to preserve, any sign of human life.

Hoskins is a professor of nursing at New York University, Steinhardt School of Education, Division of Nursing, Manhattan.

“Rather suddenly I was hustled off to a training program which normally consists of several days of a structured program.”

As O’Neil tells us, the immediate and emergent relief efforts on the part of both individuals and organizations had an enormous widespread effect on our entire society. As a member of the nursing profession, I learned that not one staff member of a hospital, not one member of the NYPD or cadre of the New York Fire Department stood still. Although not an acute care nurse, I was still a nurse, feeling an overwhelming sense that I could do something. That something, I ultimately decided, was to respond to a call from the American Red Cross for Local Disaster Volunteers. Having been informed of a plea from the American Red Cross to New York University’s Division of Nursing, I made a decision to explore how and in what way I could be of some use.

I made my way to the headquarters at Cadman Plaza, Brooklyn. The building was a huge maze of activity and what appeared to be frenetic efforts. Persistence, I decided, was the key. I learned that the Red Cross was organizing itself, although there appeared to be some disorganization. Many volunteers had been flown in from across the country, including young Americorps workers. I made my way through a series of steps and procedures, hearing in my first lecture that the Disaster Services Human Resources (DSHR) System “fires into action, moving highly trained and experienced Red Cross disaster volunteers into affected areas quickly and efficiently. It can be five blocks or 5,000 miles from your home” (ARC, 1987). “The DSHR System is designed to serve two functions: (a) to support the efforts of local Red Cross units in disaster-affected areas, and (b) to provide both new and veteran Red Cross disaster volunteers with a career-development path with Disaster Services. It is an opportunity to have more, do more, and be more on a disaster” (ARC, 1987).

Fortified with this background material to guide me, I found my way to what seemed an appropriate office to learn what the role of nursing was. I discovered that it was viewed as essential to: (a) family relief services, (b) care delivered at Ground Zero, and (c) mental health assessment and referral. I believed

that my background in community health would be most useful for family relief services and this was verified in an interview that included information on my background, skills, physical and mental health, and personal preferences.

Rather suddenly I was hustled off to a training program which normally consists of several days of a structured program. It was collapsed under the present circumstances into four hours. I learned fairly quickly that the main objective was to engage in “activities that supported mitigation — actions or measures that can reduce the severity of the effects of a disaster — and that can help save lives and property.” A volunteer works with federal agencies such as FEMA, and other organizations, to take proactive steps in an effort to alleviate the immediate needs for shelter, clothing, food, and emotional relief.

For the remaining six hours of the day, we used a three-inch thick manual to learn how to complete an extensive case record that described (a) members of the family, (b) how the family was affected in the disaster, and documentation to verify the accuracy of the required information, (c) what needs could be provided for or had been met by the family’s own resources, and (d) whether referrals had already been made to meet those needs. The next step was to learn how to write a recovery plan, and conduct a thorough review of the case in terms of a long-term plan, if indicated.

The disaster services regulations and procedures were extensive but viewed as essential to effective case management. Thus, we learned how to complete disbursing orders for non-cash grants, like groceries, housing, clothing; and cash grants, i.e., family maintenance allowance (FMA). We also learned how to complete forms for release of confidential information to other organizations such as the Salvation Army, disaster nursing referrals, home visit assignments and home visit notes, and landlord verifications. In short, the procedures were extensive, requiring a considerable amount of learning and practice.

In most instances, the person or family spoke little or no English. Often a case manager had to wait for a translator to become available. If answers could not be provided - verification of a landlord, for example - the case manager or volunteer was responsible for contacting the landlord to obtain the necessary documentation.

I was impressed by the gratitude and enormous patience of individuals seeking assistance in the aftermath of September 11th. Income, in many cases, no longer existed. Garment workers were stripped of their work or it was severely curtailed. Truckers were excluded from what was a clearly defined geographic area. Many could not re-enter their apartments to recover their personal effects. Still others suffered from upper respiratory tract irritations and infections because of the fine dust and sediment that pervaded the area. The problems were many and of a magnitude that very few of us have ever experienced.

I grew to respect enormously the long hours that the volunteers invested each day. As I arrived at the site on Franklin Street on my assigned day each week for two months, I gradually grew used to the long lines of people that stretched around the block. When I left each day, the lines often remained. On a personal note, I struggled with the opportunity offered by one of the Ground-Zero verified workers to spend several hours at the end of a day walking the area. My decision not to view the area in the first days following the disaster is still not entirely clear to me. Perhaps the comment of one of the Americorps workers with whom I worked as a partner convinced me that this was a scene that would be almost unbearable to view. I concluded that I was already experiencing the effects of human tragedy through the media, and through sharing the loss and pain of those who sought our help. As a result of experiencing the tragic loss of my one sibling at age 37, I was not a stranger to the ebb and flow of intense grief. I also knew that if one allows the grieving process to happen, the intensity of each episode gradually lessens over time and, thankfully, is replaced by healing.

As a member of the faculty of the Division of Nursing at New York University, I observed the enormous impact on the university community; students, faculty, and staff contributed their talents and efforts in their own way. One student, Danielle Briscoe, since graduating from the College of Arts and Sciences, retained her commitment to community service, training as a member of the Red Cross Disaster Action Team. She recalls how her team was deployed and assigned to provide mass care by noon on September 11th:

Our job was to escort a team of mental health workers to Ground Zero and distribute food ... We were supposed to look for walking wounded and help them find assistance. But there weren't any. By the time we arrived, the firefighters and rescue workers were already hungry and we ran out of food very quickly." Briscoe was at the site until

midnight. "In a disaster you're not supposed to exceed a twelve-hour shift. By the time we returned to headquarters, there was no food left. The volunteers were exhausted. It was very chaotic," she recalls, "very stressful. You could just see the exhaustion but everybody just kept going, doing what they knew how to do but doing it in a state of shock and numbness" (NYU, 2001, p. 16).

The actual events of September 11th are over but the effects will never disappear, and it is imperative that we not forget. My own memories of those who struggled to cope with the aftermath of loss and grief will remain with me forever. O'Neil (2001) comments, "A reassessment of broader trends has begun ... The national mood has changed." Perhaps there are many things to be learned from September 11th and gradually over time, we will find some constructive outcomes.

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INFORMATION FOR AUTHORS

Journal of the New York State Nurses Association

11 Cornell Road, Latham, New York 12110
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Jones is a clinical nurse specialist in oncology at University Hospital in Hometown, NY.

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Crisis Theory and Intervention: A Critical Component of Nursing Education

Carla Mariano, EdD, RN, HNC

ABSTRACT

Nurses deal daily with clients and families whose lives are in crisis, yet many feel educationally and professionally unprepared to intervene effectively in crisis situations. The author describes a course in Crisis Theory and Intervention offered to master's level nursing students. The importance of knowledge and skill in this area for practicing nurses and the need for incorporation of this content in nursing educational programs are discussed.

Introduction

The need to prepare nurses in crisis theory and intervention continues to rise. Since September 11, 2001 and the attacks on the World Trade Center and Pentagon, the United States is changed. We are now enduring the anxiety and stress of potential future attacks, the sadness and grief for those lost, and the stress of waging war in a foreign land. The toll in terms of stress-related illness and unresolved and problematic grief have yet to be measured. Clearly in New York City alone many are still suffering from sleeplessness, grief, anger, anxiety, fear, and numerous stress-related physical symptoms. Many continue to have intrusive visions of the planes hitting the tow-

ers, and the collapse, fire, and dust. A poll reported in the *New England Journal of Medicine*, (Schuster et al., 2001) of 560 adults and children showed that 44% of adults reported substantial stress symptoms and 68% experienced one symptom moderately. People living closest to New York had the highest rate of substantial symptoms, but others throughout the country suffered substantial symptoms as well. Thirty three percent reported that their children had at least one of five major stress symptoms, and 47% reported that their children were worrying about their own and their loved ones' safety. Nurses in all areas of practice will need to be especially knowledgeable and observant of stress reac-

tions related to these recent events. Helping people resolve stress reactions may prevent the later development of chronic anxiety, depression, heart disease, and other stress-related illness.

According to a recent article in *Crain's* (Messina, 2001), "Illegal drug use is one of a host of symptoms, including insomnia, depression and general anxiety, that mental health experts are seeing two months after the attack. But any sustained increase in drug use could be ominous for the city because it could trigger increases in crime. Public health experts are also concerned because a rise in illegal drug use can lead to a rise in AIDS, hepatitis and other diseases" (p. 47).

Mariano is an associate professor and coordinator of the Advanced Practice Holistic Nursing Program at New York University, Manhattan.

Nurses trained in crisis theory and intervention strategies are in a particularly valuable position to assess and relieve stress and pain. On the day of, and following, the tragedy on September 11, nursing faculty and students from New York University's Division of Nursing were called upon and responded heroically to the needs of the disaster victims by providing emergency services and counseling. As the nation approaches the anniversary of the World Trade Center tragedy, the need for expert stress and trauma management will continue to be felt not only in New York City but in all areas of the country.

Definitions

James and Gilliland (2001) define crisis as a "perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. Unless the person obtains relief, the crisis has the potential to cause severe affective, behavioral, and cognitive malfunctioning" (p. 3). Parad and Caplan (1966) define crisis as "the impact of any event that challenges the assumed state and forces the individual to change his view or readapt to the world, himself or both" (pp. 66-67).

There is a hazardous event which is a threat to fundamental instinctual needs or a sense of integrity; there is a link to earlier threats and often reactivation of old, unresolved conflicts; there is an inability to respond with adequate coping mechanisms — something so new that the person does not have coping devices to deal with it. As a result, anxiety and tension increase, effective cognition functioning decreases, and behavioral disorganization follows (Parad & Caplan, 1966).

The Chinese character for crisis represents both "danger" and "opportunity" — a danger because it threatens to overwhelm the indi-

vidual, family, or group, and an opportunity because during times of crisis, people are vulnerable and much more receptive to therapeutic influence and help from others. This brings with it the possibility of growth and change. The Greek word for crisis is "turning point," again demonstrating the peril and the opportunity for positive resolution and growth that crisis presents.

"Crisis occurs so often in the lives of individuals and families that it seems an inevitable part of human existence." (Janosik, 1994, p. 3) Janosik further notes that:

It is unfortunate that with few exceptions crisis theory and practice receive only cursory treatment in the education of health care providers and other professionals. Crisis is a recurrent part of the human experience, and theories from which crisis work is derived deserve more visibility in professional educational program (Janosik, 1994).

Practicing nurses deal with individuals and families in crisis on a daily basis. In an effort to help masters-level nursing students deal with their clients' crises and to decrease the gap between crisis theory and practice, the author developed and offers a course, *Nursing Strategies: Crisis Theory and Intervention* for graduate students at New York University.

Survey of Students

To determine students' conceptions about crisis and prior knowledge about crisis theory and intervention techniques, the instructor distributes an anonymous survey during the course. The following illustrates responses of the students to questions regarding their prior knowledge and understanding.

In addition to prior knowledge, students were asked what their understanding and conceptions of individuals or families in crisis were

Table I. Prior Knowledge of and Conceptions about Crisis

Extent to which your baccalaureate nursing program taught you crisis <u>theory</u>	None (22%)	Minimal (59%)	Some (13%)	Extensive (6%)
Extent to which your baccalaureate nursing program taught you to <u>intervene</u> with <u>individuals</u> in crisis	None (13%)	Minimal (69%)	Some (12%)	Extensive (6%)
Extent to which your baccalaureate program taught you to <u>intervene</u> with <u>families/groups</u> in crisis	None (25%)	Minimal (47%)	Some (22%)	Extensive (6%)
Extent to which your baccalaureate program taught you stress management techniques or how to deal with your own stress	None (34%)	Minimal (44%)	Some (22%)	Extensive (0%)
Have you attended a staff development or in-service program on crisis intervention at your employing institution?	Yes (9%)	No (91%)		
Have you attended workshops/conferences on crisis intervention?	Yes (12%)	No (88%)		
Frequency with which you deal with clients/families in crisis in your work	Never (0%)	Once or twice/month (6%)	Once or twice/week (22%)	Every day (59%)
		Three or four times/day (13%)		

“Emotional threats to clients and families may be overlooked by health personnel who concentrate only on the life-threatening aspects of the experience.”

and how they intervened with individuals or families in crisis before taking this course. Most students considered a crisis to be an event — an emergency, disaster, or monumental situation. Students used the word “chaos” when describing individuals in crisis; yet many students indicated that they had no realization that people in crisis were cognitively disorganized, out of control, and overwhelmed. Students often equated crisis with stress. There are many definitional problems with the concept of crisis and suggest that with this lack of clarity, it is difficult to determine whether a crisis state exists and, therefore, which interventions are most appropriate and effective.

Students described people in crisis as unable to cope with their present situation, and in need of assistance, a listening ear or a “shoulder to cry on.” A discrepant finding revealed that some students thought the crisis situation would eventually work itself out, while others thought that the situation would “go on forever.”

Responses to the question, “How have you primarily dealt with individuals and families in crisis?” divided into three categories: actions, feelings, and use of resources.

The most typical actions identified by these graduate nursing students when dealing with individuals or families in crisis were avoidance, ignoring the emotive aspect of the crisis by focusing exclusively on the medical emergency, and keeping busy. A number of students cited the use of avoidance in dealing with crisis situations, connoting a lack of assessment of the situation. Regarding communication with people or families in crisis, students suggested that they sometimes give facts, advice, opinions, and often too much direction. Many cited the use of clichés, e.g., “Everything will be all right” or vague, non-specific answers in their communications with patients and families. Frequently, a hasty referral is made to social services.

Research shows us that there is a direct connection between stress and health/healing. Therefore, it is imperative that health professionals attend to both the physical and emotional factors of an emergency. This of-

ten presents a problem for health providers who are accustomed to giving only medical treatment. Janosik (1994) suggests that professionals who are well trained in the medical aspects of acute emergency are often unaware of the multifaceted nature of crisis and, therefore, restrict their assistance to interventions that are exclusively medical. There is a need for comprehensive training of medical personnel, which requires sensitizing them to the emotional components of a medical crisis. Emotional threats to clients and families may be overlooked by health personnel who concentrate only on the life-threatening aspects of the experience.

Greenstone & Leviton (2002) contend that a major obstacle to successful crisis intervention arises from faulty technique, i.e., failure to assess the problem, failure to utilize a crisis approach, and over-involvement with the clients and family. This leads to a concomitant loss of professional position and to hasty referrals without assessing the problem, knowing the resources, or eliciting the client’s ideas and feelings about the referral. Puryear (1981) offers valuable suggestions for dealing with these obstacles. He emphasizes that there exists a base of knowledge and specific skills that can be learned. Therefore, any crisis situation can be approached in an organized, systematic way. Health providers then can know what they’re doing, why they’re doing it, and what they’ll probably do next. This will increase both the workers’ confidence and their effectiveness.

Most students in the course, when dealing with people in crisis, expressed feelings of discomfort, frustration, a need to solve everyone’s problems, inadequacy, and fear of saying or doing the “wrong” thing lest they intensify the situation. Many stipulated that they wanted to “help, calm or comfort” the client or family, yet they did not know what to do or how to handle the situation. A number of students become “caught up” in the crisis, feeling anxious, out of control, and, consequently, drained by the entire experience.

Puryear (1981) states that the most troublesome feelings for crisis workers tend to be anger, frustration, depression, inad-

equacy, and helplessness. He notes that a sense of omnipotence — an image of the all-knowing, all-caring professional who can and must solve all problems for the client often underlies these troublesome feelings. Most authors in the area of crisis iterate the need for collaborative efforts in intervention. Professionals must be cognizant that “crisis is not an issue that need be handled by a single individual ... Recognition that crisis is a multidimensional situation enables the crisis worker to realize the value of interdisciplinary collaboration” (Janosik, 1994, pp. 435-436).

Many students implied that the hospital system itself does not provide the support for staff to intervene in crisis situations. Puryear (1981) suggests that often bureaucratic systems are not structured to provide maximal assistance to clients. He contends that in crisis intervention work, “One needs experience and skills in working with, in, through, around, and on rare occasions, against systems” (p. 167). For effective crisis intervention there must be appropriate administrative policy, personnel training, physical space, and coordination with other delivery systems. Janosik (1994) views the provision of a nurturing, supportive environment for staff as the “primary level of crisis prevention.”

As suggested from the survey responses, the majority of these masters nursing students felt professionally ill-prepared, inept, and uncomfortable in dealing with individuals and families experiencing crisis. Most expressed a need for definitive knowledge and understanding of crisis theory and specific techniques which could be utilized in their nursing practice. Two students aptly reflected the sentiment of the class when they stated, “Working in stressful settings where there is a constant flow of crisis situations makes crisis theory and crisis intervention crucial to nurses’ knowledge base” and “As nurses we are always working with people and usually in a crisis state. It only seems appropriate that we are taught how to handle such situations.”

Nursing Strategies: Crisis Theory and Intervention Course

Theoretical Perspectives Covered in the Course:

The Crisis Theory and Intervention Course is offered as a three-week concentrated, summer course, meeting four days each week. It is a 3-academic credit, 30-hour elective, didactic course for all masters students in the New York University Division of Nursing. (Figure 1.)

Figure 1. *Crisis Theory and Intervention Course*

- Historical Evolution of Crisis Theory
- Current Research
- Theoretical Perspectives of Crisis
- Issues in Crisis in Intervention
 - Crisis intervention paradigms vs. the medical model
 - Cost effectiveness
 - Reimbursement issues
 - Professionals and non-professionals as crisis interveners
- Common Myths
- Definition of Crisis
- Major classifications/typologies/origins of crisis
 - Anticipated maturational/development
 - Unanticipated situational/social
 - Dismemberment
 - Accession
 - Demoralization
- Assumptions of Crisis Theory (LIVE or EVIL)
 - Loss
 - Interpretation/perception
 - Vulnerability
 - Empowerment
- Growth and Change
- Dynamics and behaviors of individuals/families/groups/communities in crisis
 - Cognitive
 - Affective
 - Behavioral

Interventions Covered in the Course:

- Screening/Assessment
- Generic/Individual
- Problem Solving
- First Order Intervention: Psychological First Aid (Slaikeu)
- Multimodal Crisis Therapy (Slaikeu)
- Hoff
- Burgess and Baldwin
- James and Gilliland
- Psychological Phases of Crisis in Organizations (Fink)
- Decision Making (McCool and Brown)
- Massive Psychic Trauma (Krystal's original work)
- Post-Traumatic Stress Disorder
- Compassion Fatigue/Secondary Traumatic Stress Disorder (Figley)

Case Studies:

Exemplar case studies on suicide, victimization, physical and sexual abuse, Alzheimer's, substance abuse, community disaster, and a hospital unit in crisis are used during class to further the students' understanding of individuals and groups in crisis and to demonstrate appropriate and effective intervention strategies. Two films on Non-violent Crisis Intervention, developed by the Crisis Prevention Institute (2001), are used to depict the use of preventative and non-violent physical crisis intervention techniques with clients.

Community Resources:

Additionally, the students are exposed to a number of community based crisis counseling services in the New York City area to demonstrate the variety of resources available to practitioners and the range of techniques utilized with people in crisis. Representatives of the Samaritans, Victims for Victims Support Groups, Victim Services, The St. Mary's Hospital Emergency Mental Health Services' Mobile Crisis Unit, and the Bellevue Hospital Interdisciplinary Child Abuse Team describe their organizations, illustrating the particular intervention techniques used with their clients.

Care for the Caretakers

Within the past decade there has been an upsurge in the published literature on work stress and burnout in healthcare providers, especially nurses. The effects of constant intense involvement with clients in acute stress are cumulative on the healthcare provider. In the health professions, providers must respond to clients and families experiencing acute crisis, as a major aspect of their clinical responsibility. Because of this, burnout among health professionals becomes very real and problematic if not anticipated and if preventive measures are not taken. As Figley (1995) states, "We have a special obligation to our students and trainees to prepare them for these hazards. A place to start is to incorporate stress, burnout, and compassion into our curriculum and especially our supervision in practice" (p. 17).

An important aspect of the *Crisis Theory and Intervention* course is the discussion of burnout and the more recent concepts of *vicarious traumatization, compassion fatigue, or secondary traumatization* in the individual who works with people in crisis. "Occupationally, burnout occurs when [there are] demanding and overbearing bosses, unending blizzards of paperwork, ...jack-of-all-trades-and-master-of-none job descriptions, catastrophic dilemmas far beyond the expertise of the worker, ironclad and unbending institutional rules and procedures, communication problems, and 16-hour workdays ... It is experienced as a state of physical, mental, and emotional exhaustion...accompanied by an array of symptoms including physical depletion, feelings of helplessness and hopelessness, disillusionment, negative self-concept, and negative attitudes toward work, people, and life itself" (James & Gilliland, 2001, p. 611). Vicarious traumatization and compassion fatigue, which are very real, definite negative results that occur when individuals have prolonged exposure to clients and families in crisis are an occupational hazard for nurses. It is important that early in a nurse's education emphasis be placed on an exploration of attitudes and values that lead to over involvement. Students need to explore their own issues and conflicts and how these might mirror or reflect the client's.

To assist these graduate nursing students in dealing with their work-related stress or what Janosik (1994) refers to as the "trauma of crisis for caregivers," they are introduced to select stress reduction techniques. Centering, deep breathing and muscle relaxation tech-

niques, guided imagery, and brief meditation are presented and practiced during the class. These techniques are easily learned and can be incorporated into the busy work schedules of practicing nurses.

Evaluation of students

Students in the course are evaluated through use of a case study of a family experiencing a crisis, e.g., a family member's recent diagnosis of Alzheimer's disease. Students write a complete assessment, identify and give a rationale for a model of intervention, apply the model and its intervention strategies to the crisis situation, include strengths and limitations of the model of intervention, and identify and evaluate hypothetical outcomes of intervention.

Student Evaluations of Course

End of course evaluations were based on a standardized course evaluation form and an anonymous questionnaire developed by the instructor. Four open-ended questions addressed changes in the students' understanding of crisis theory and interventions as a result of the course and the most important aspect/learning of the course to them professionally and personally. An analysis of the responses in these four areas revealed the following:

Changes in Understanding: Most students in the course indicated improved knowledge and a much clearer understanding of people in crisis and crisis resolution. Many stated that the course completely changed their approach to crisis situations. In contrast to prior conceptions of crisis, students now comprehend crisis to be a process with specific phases and origins. Crisis is not the *event*, but the perception, meaning, and interpretation it has for the individual.

Students recognized that during crises, there are many factors operating and that one person in crisis affects the entire family. Students also noted the importance of assessment and evaluation. A consistent theme was the enlightening realization that crisis is both a danger and an opportunity for growth and change. As one student stated, recognizing this concept was "empowering."

Changes in Interventions: Present and future changes in interventions were described by the students in three areas (general preparation, specific interventions, and feelings). Students indicated that they were now more prepared to deal with clients and families in crises in a professional and therapeutic manner. They reported having a much better understanding of what to do and what to say. They were aware of different intervention models, approaches, and techniques, and their interventions would now be based on theory.

Students described their ability to assess more quickly and to base their interventions on a relevant, accurate assessment of the phase of crisis, the precipitating event, problem solving and coping mechanisms, cultural background and values of the person in crisis. Students noted the importance of intervening before the "flash point" and being more alert to the involvement of others in the crisis situation. They felt more prepared to assist the individual and family in crisis to see the reality of the situation, to give families control and choice in decision making, and to work together with families in planning and priority setting. Students further indicated that they have an increased awareness of crisis prevention and appropriate, available resources. One student suggested

that she "had gained a whole new respect for the team approach. No one should become the exclusive caretaker and foster unnecessary dependence in the client." All students expounded on the value of "really listening" to and spending time with the person in crisis. As one student declared, "Most of the time people do not want your opinion, they just want to vent. I'll never say 'I understand' ever again!"

Students in the course indicated feeling more comfortable, patient, calm, and confident in dealing with the clients' and family's fear, anger, and frustration. They felt they now recognized and could deal appropriately with their own fear of becoming enmeshed in the crisis. A number of students noted their need to be less paternalistic, realizing that they cannot solve everyone's problems. One student stated, "I had the opportunity to examine my 'rescue or savior' behavior and change it without losing compassion and sensitivity." A common theme among the students was that they felt better equipped to help others and themselves, knowing that crisis is time limited and can provide the opportunity for growth and development.

Most Important Aspect of the Course to You Professionally and Personally: Many students reported that, as a result of the course, their scope of practice had broadened and become enriched. Common remarks

were: "As a nurse, I feel I was lacking an extremely important aspect of my work, helping those in crisis. I had no idea my actions were so inappropriate during times of crisis" and "Previous to the course, I just didn't know how to handle crisis and be helpful to clients." One student's summary reflected the attitude of the class: "Studying something as devastating as crisis and understanding that there is a logical, planned, structured way to help people in crisis is professionally very rewarding." Most students believed that they had grown professionally and personally through participating in the course and that it had assisted them to deal with crisis as it occurs in every aspect of their lives. They also implied that they had learned much to prevent burnout in practice.

In the personal realm, many students indicated that the course made them realize how many crises they had undergone in their own

lives, yet were not aware that they were in crisis. "The readings and class discussions, helped clarify past crises, enabled me to understand why they occurred, evaluate how I handled them, and helped me see how I might handle them now. Recalling the pain and emotions without being in an active crisis allows you to gain a whole new understanding and perspective." "Understanding that crisis often brings up old, unresolved problems was a very valuable and enlightening thought." Students felt the course had helped them clarify their personal strengths and limitations.

The majority of students expressed confidence that if they or their family or friends were in a crisis, they could utilize their newly acquired learning and respond more effectively. "We are human too and not immune to our crises. This course is applicable to learning how to better understand and intervene in any crisis including our own." Again, the appreciation of the growth potential of crises was cited by most students. "Life teaches too — people can benefit not just survive ordeals in life."

Regarding the course format, some students found the intensity of a three-week summer course challenging but felt that the immersion in the material enhanced learning. Both the instructor and the students

"Crisis is not the event, but the perception, meaning, and interpretation it has for the individual."

thought that the incorporation of an experiential component to the course would be a valuable addition. Although the condensed time period did not permit a live experiential component, student evaluations did indicate that some were already integrating crisis intervention techniques learned in class into their practice. Many students positively evaluated the sharing of ideas gleaned from personal experience and class materials, and the interactions among students and between students and instructor.

Nursing Perspectives

As noted above, nurses deal daily with client and families whose lives are in crisis. Siegel, Slaikeu, and Kimbrell (1984) state "...nurses and other health professionals have a direct impact on how their patients' resolve life crises" (p. 243). In recognition of this belief, the students in the Crisis Theory and Intervention course were asked their perception of the importance of this content to nurses. These graduate nursing students unanimously concurred that knowledge of crisis theory and crisis intervention was essential in the practice of nursing. The following statements attest to these practicing nurses' beliefs about the need for this knowledge.

"All aspects of nursing confront crisis — it is basic to the human condition. Hospital nurses deal with crises every day, community nurses see crises in clients' homes, administrators deal with staff's crises." "Who better than nurses who are with clients the most can assess and intervene where necessary." "Anyone who enters a hospital is a potential 'crisis candidate.' Sometimes we don't realize this because we become immune to it." "We're exposed to many forms of crisis and feel unprepared but say nothing and blame ourselves if we feel we haven't been helpful." "Understanding the concepts of crisis and using models of crisis intervention 'de-mystifies' crisis theory and intervention techniques and makes one feel capable of helping people deal with crises." "If all nurses had crisis intervention training, we could *prevent* many potential crises from happening — unfortunately, we don't." "Accurate assessment and intervention can truly mean the difference between a positive or negative outcome to the crisis. We can impact so many people in the way we respond to their crises." "After such a course, we have another tool of the trade. Hopefully, we won't go on 'automatic pilot' anymore." "Nurses are the ideal profession to expand the area of crisis research and crisis theory."

In addition, students cited the need for nurses to be familiar with

techniques to reduce their own stress, tension, and anxiety. "Nurses need to be able to function themselves in order to work effectively with patients and families. This is why stress management is so important." "Stress reduction techniques are very helpful in coping with the increasing demands of the profession as well as the increasing demands of the clients and families."

A number of students felt strongly that this content or a course of this nature should be *required* on the undergraduate as well as graduate level.

Instructor's Reflections

As all of these students hold a baccalaureate degree in nursing, are at various stages in their masters education, and have a range of years in practice, I did not anticipate the minimal knowledge and understanding of crisis theory and intervention expressed by the students. When the course began and the above became apparent, I initiated a much more interactive teaching style, utilizing the student's actual practice experiences with clients and families to illustrate basic concepts of crisis theory and intervention. This approach was evaluated very positively by students and seemed to make the theoretical material readily useable for them.

Another unexpected finding was the students' lack of realization that crisis theory and intervention techniques are equally applicable to the organizations in which they work. The use of one student's experience with a hospital unit in crisis exemplified the dynamics and phases of an organization in crisis and also assisted students to consider various techniques that they as professional practitioners could implement to resolve the problem.

I was surprised to find how meaningful the course material was to the students personally. This illustrated to me that we in professional education must not only assist students to view clients in a holistic manner but also consider the holistic needs of those we teach.

Conclusion

Crisis signifies a turning point, a danger or an opportunity for growth. Dealing with clients and families experiencing crises is integral to the practice of nursing. Inattention to crisis theory and application in the educational preparation of nurses evokes a danger — the lack of essential knowledge and skill in a nurse's practice armamentarium. Incorporation of this content in basic and advanced nursing education provides for the professional and personal growth of nurses and also increases the quality of health care to clients and families.

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Reflections on September 11, 2001

Jackie Cataldo, BSN, RN

SMOKE AND DEBRIS

Smoke and debris
Swirling mist in the artificial light.
Eeriness prevails the night.

Hell living through this tragedy.
Living?
Bodies mingled with concrete and steel.
Shattered glass and shreds of clothing.
Our mothers, fathers, sisters, brothers
and friends gone.
Breath crushed, seared from their lungs.
Hearts and children left alone. Pain.
Insurmountable pain for the buried
and the walking wounded.

Scream, I want to say to the rescue workers.
Eyes blank.
Staring at everything and nothing.
Scream your soul.

I want to touch your face,
Hold your mud-encrusted hand.
You look into my eyes, holding tight
to my insides.
Your mouth almost smiles.
Energy low.
I smile for you.
Slowly, we pass each other and move
into the quiet thumping of the night.

COLORS

The children draw pictures.
Airplanes crashing into tall buildings.
Firefighters, police officers and
construction workers.
Swirling hoses and axes suspended in midair.
Nurses' caps and helmets perched on
small tilted heads with oversized
bodies.
A crucifix, stethoscope and stars and
stripes tell the story.
Testimonies set on paper with care
and determination.

H-E-R-O-E-S,
The letters are scrawled at the top of the page.
Bright crayon colors depict the horrors
captured by TV cameras.
Repeated again and again.
Images expressed through baby eyes.
Prayers, thanks, sadness and hope mixed with
sequins and glue.

THERE IS A WAY

There is a way, they say, to resume life.
There is a way, they say, to look at the mass
destruction and not see it.
There is a way, they say, to focus instead on
the workers who still emerge from subways
every day.
There is a way, they say, to forget the silenced
heroes who sat at their desks doing what
they did the day before, and the day before
that.
There is a way, they say, to obliterate from
our minds the shattering of life that took
place in the second it takes to blink an eye.
There is a way, they say, not to hate the
destroyers.
There is a way, they say, to leave behind the
anger and fear that wakes me in the night.
There is a way There is a way.....
There is

VENDORS

They stand on every corner.
Selling the tools of death.
Red white and blue.
Colors imprinted as stripes
and stars on silk and metal.
Tall buildings, 8x10 glossy finish.
Get your red hot towers,
the vendors scream with unmoving lips.
Silent screams Jesus would
have condemned.
Buy the flags that divide human beings.
You American, You Israeli, You Arab.
Hang your colors in the car or
around the neck.
Display them in windows or
paint them on fingernails.
Be suspicious of those who don't.

BUTTERFLY

Dust begins to fill the wing-shaped
cavities.
The powder swirls about settling on
the stiffening cilia.
Poisons collect slowly.
The butterfly expands less and less now.
The swishing sounds difficult to hear.
No air she cries.
A cell phone rings.
No one to answer.
Not too long now.
Slowly, sounds subside..

Cataldo is a nursing representative and organizer for NYSNA and an American Red Cross Volunteer, serving as a member of the Brooklyn Disaster Assistance Team and an instructor for Disaster Health Services.

Nursing at Ground Zero: Experiences During and After September 11 World Trade Center Attack

Suzanne Steffan Dickerson, DNS, RN
Mary Ann Jezewski, PhD, RN
Christine Nelson-Tuttle, MS, RNC
Nancy Shipkey, MS, RN
Nancy Wilk, MS, RN
Blythe Crandall

ABSTRACT

The purpose of this study is to discover shared perceptions, feelings, and common experiences of nurses after the September 11th World Trade Center terrorist attack through interpretive analysis of narrative stories of seventeen nurses. Six themes and one constitutive pattern describe the experiences: (a) Loss of a symbol and regaining new meaning, (b) Disaster without patients, (c) Coordinating with and without organizations, (d) Rediscovering the pride in nursing, (e) Traumatic Stress, and (f) Preparing for the future. The constitutive pattern is that nursing enables a humanitarian disaster response.

The events of September 11th, 2001 were the United States' most devastating terrorist attack in history. Until that day, terrorism was a problem in other countries, far away from the U.S. When two jetliners crashed into the twin towers of the World Trade Center (WTC) early that Tuesday morning, area hospitals activated their disaster plans and began preparing for enormous numbers of injured victims. Nurses were prepared to stay at their hospitals and care for the wounded for as long as needed. The purpose of this study is to discover shared perceptions, feelings, and common experiences of nurses after the September 11th terrorist attack. These shared experiences give voice to the nurses. Their voices can provide insight into the experience of disaster nursing and will help nurses understand and prepare for similar experiences.

Literature Review

Between the years 1980 and 1990, there were 12,216 individual terrorist bombings in the United States, increasing each year within that decade. Along with the increase in the number of incidents, the weapons used became more and more destructive. In the year 1990, 1582 bombings occurred in the U.S., resulting in 27 deaths (Karmy-Jones, Kissinger, Golocovsky, Jordan, & Champion, 1994). In 1995, the well known bombing of the Murrah Federal Building in Oklahoma City resulted in 167 deaths from a single incident (Slater & Trunkey, 1997).

Terrorist attacks are meant to produce terror, not necessarily mass casualties. Because of this, they have historically involved small explosives, low mortality rates, large numbers of minor injuries, and general panic. Recent events such as the September 11th crashes and

the Oklahoma City bombing constitute a re-evaluation in how we think of terrorist attacks in terms of number of fatalities, but the distribution of casualties is similar to previously collected data concerning terrorist bombings (Frykberg & Tepas, 1988). In a *Morbidity and Mortality Weekly Report* (2002) of rapid assessment of injuries among WTC survivors, only 18% of those treated at local emergency rooms within the first 48 hours were hospitalized, indicating the low percentage of severe injuries in spite of the massive mortality.

Frykberg and Tepas studied 220 terrorist bombings worldwide that occurred between 1969 and 1983 resulting in 3357 casualties. None of these attacks occurred in the United States, which is indicative of the lack of experience healthcare workers have with disasters of this nature.

Suzanne Steffan Dickerson is an assistant professor of nursing; Mary Ann Jezewski, an associate professor of nursing; Christine Nelson-Tuttle, a doctoral nursing student; Nancy Shipkey, a doctoral nursing student; Nancy Wilk a doctoral nursing student; and Blythe Crandall, a baccalaureate nursing student, at The University at Buffalo-SUNY, Buffalo, New York.

Responses to Disasters

Disasters take many forms. Demi and Miles (1984), in their article examining nursing leadership after the 1981 collapse of the walkways in a Kansas City Hyatt hotel, identify the differences between natural and man-made disasters. Natural disasters involve forces that are usually outside of human control: hurricanes, tidal waves, earthquakes, floods, volcanic eruptions, and so forth. Man-made disasters, which include plane crashes, structural collapses, explosions, and warfare, are perceived much differently by those who are affected by them. Man-made disasters are more difficult to deal with psychologically, because they are perceived to be, or actually are, the result of malicious intent or incompetence.

In a study of emergency department impact of the bombing in Oklahoma City, Hogan, Waecherele, Dire, and Lillibridge (1999) found that only 9.7% of patients received in emergency rooms had been rescued from the rubble, with a median rescue time of 20 minutes. It is estimated that most victims trapped in buildings that have been bombed will be removed within 30 minutes, so this number is actually below average (Anteau & Williams, 1998). Although this timeframe, as well as the expectation that most survivors of terrorist attacks will have non-critical injuries, may be well established, it has never hindered the efforts of the public and hospital staff or dimmed their hope for late survivors.

Disaster Planning

The need for all healthcare personnel to have disaster training is extremely important because of the unpredictability of these events. Nurses never know if they will need to be the first responders to a mass casualty event, as the nurses at the Hyatt Hotel disaster discovered. Suserund and Haljamae (1997) studied the experiences of nurses at two Swedish train accidents. One train collision occurred near a small health center, and doctors and nurses immediately responded until emergency teams from a larger hospital arrived on the scene. The health center nurses, who had little emergency or disaster experience, initiated no leadership actions and felt less prepared to deal with the situation. This experience was mirrored by volunteer nurses without disaster experience at the Hyatt walkway collapse. In addition, these nurses experienced more emotional stress than trained personnel following the event (Demi & Miles, 1984).

Psychological Responses

Psychological responses to disasters are important areas to consider. North et al. (1999) analyzed the prevalence of psychiatric disorders in a sample of 182 adult survivors of the Oklahoma City bombing, and found that 45% of them had developed a post-disaster disorder. Thirty-four percent of the sample met the criteria for post-traumatic stress disorder (PTSD), and 76% of those reported symptoms developing the day of the explosion. Those most likely to develop a post-disaster disorder or experience recurrence were: women, victims with more acute injuries, survivors who had close relationships with those who had been injured or killed, and individuals with pre-existing psy-

chiatric diagnoses. Even in those subjects who did not meet the diagnosis for PTSD, symptoms of intrusive re-experience and hyperarousal were common.

While much of the literature describes the impact, responses, readiness, and training needs of different disasters and terrorist acts of smaller proportions to the September 11 event, there is a need to understand the personal experiences of nurses at or near Ground Zero. The specific aims of the study were (a) to describe the nurses' experiences immediately after the September 11 WTC attack, (b) to describe nurses' perceptions of their professional and personal preparation and readiness for such a disaster, and (c) to describe the preparation nurses need to practice in similar situations.

Research Design

The methodology is Hiedeggerian Hermeneutics, an interpretive phenomenological approach where the researcher examines written or spoken text (language) to disclose the meanings of the experiences (Heidegger, 1962). Interpreting the narratives of nurses who worked at Ground Zero enables us as researchers to be involved in and understand the practical knowledge of his or her world.

Procedure

The researchers invited nurses who were involved with the September 11 terrorist attack in New York City to join the study to describe their experiences. Nurses were recruited by posting flyers at the NYSNA convention

on Nov. 1-2, 2001, in New York City, and posting an invitation in the NYSNA newsletter, *Report*. Letters of consent and brief demographic surveys were sent to the volunteers. Upon receipt of the signed consent, the research team contacted the volunteers to schedule an interview at their convenience. The interview consists of broad open-ended questions regarding experiences during and after the attack. The majority of the interviews were conducted by telephone. The interviews lasted approximately one hour and were transcribed verbatim.

Analysis

Narratives [texts] used in this study were interpreted by the seven-stage hermeneutical process described below (Diekelmann, Allen, & Tanner, 1989; Diekelmann & Ironside, 1998). Stage one: Each researcher examined the text as a whole to gain an overall understanding. Stage two: Each researcher identified possible common meanings of the texts with excerpts to support the interpretation. Stage three: The researchers compared their interpretations for similarities and differences at weekly meetings, reaching further clarification and consensus by returning to the original text. Stage four: All texts were reread to uncover themes that linked them. Stage five: Researchers described a constitutive pattern that showed the relationship between themes across all texts. Stage six: Themes were validated by a group of participants from the study. Stage seven: The principal investigator produced a final summary including quotes that allow for validation by the reader. The multiple levels of interpretation exposed conflicts and inconsistencies in the analysis and eliminated unsubstantiated meanings. Although there is no single correct interpretation, continuous examination of the

“Interpreting the narratives of nurses who worked at Ground Zero enables us as researchers to be involved in and understand the practical knowledge of his or her world.”

whole and the parts of the text with constant reference to the text ensured that interpretations were grounded and focused (Diekelmann & Ironside).

Findings

Seventeen nurses, 2 males and 15 females, comprised the informants. The mean age was 47.7 years (s.d. = 8.4) with a range of 32-64. Ethnicity included 13 white, 2 black, 1 Native American and 1 Asian. Education of the participants included masters (9), baccalaureate (5), associate (2), and diploma (1). Specialty areas included emergency room (4), acute care (2), home care (1), administration (3), pediatric (3), psych/mental health (3), and nursing education (1). The nurses' roles in the disaster included triage (3), coordination (7), care giving and counseling (7).

Six themes and one constitutive pattern emerged. The themes are: (a) loss of a symbol, regaining new meaning. (b) disaster without patients. (c) coordinating with and without organizations. (d) rediscovering the pride in nursing. (e) traumatic stress. (f) preparing for the future. The constitutive pattern is: Nursing enables a humanitarian disaster response.

Theme one: Loss of a symbol — Regaining new meaning

New York City is a vibrant city. The informants often referred to it as "my city." The twin towers of the WTC were a symbol of the engineering, financial and marketing potential of the city. As one nurse said, "They were identified markers I knew." Thousands went to work there every day, tourists visited, and countless others observed the towers in the skyline. Often at night they would gaze at the skyline. "I always go out and look up at the towers every night."

After September 11, everything changed. As one said, "I usually see the towers...I looked up 14th Street and there were no towers, absolutely no towers, and my body just shuddered, very fearfully." Another related, "The sense of destruction was overwhelming, it changes the game completely, in a minute, everything is taken away from you." Another said, "When the towers collapsed, the hospital was engulfed by a cloud of grit and debris that seeped through cracks in the windows." Another related, "No one was ready for this. No one thought the building would fall, no one was prepared for that at all."

In essence, "The city was shut down." The city was not functioning as usual. The city that normally transports thousands to work was compromised and failed. No trains were running and, "You couldn't get past police barricades." Nurses had to hitch rides with police vehicles, or were left frustrated trying to get into work.

During the initial hours of the disaster there was a sense of the unreal or surreal. "People were walking in [into the hospital] covered with gray ash and dust." "We tried to discharge patients but they were afraid to leave" as the rumors flew that "it's the end of the world." Others at Ground Zero, the area of destruction, said, "It was terrible to see a fire truck, such a big sturdy vehicle, crushed like a toy truck" and "to see everyone with dazed looks on their faces, eerie silence, people so overwhelmed with the sight they could not speak." Time seemed to stop. "The day no longer had reference points, very blurred." Informants described the WTC as becoming "ashes and a grave of thousands." The absence of the towers became a constant reminder of this loss.

Later that evening as a nurse was walking home from the hospital, "I felt like I never did before; I had a strange, eerie feeling; all the stores were closed, hardly any busses; there were police and national guard

posts; they shut down Manhattan. They had already started memorials with candles and pictures." Another nurse described "on my way home that night I would see the towers, and that night, — not seeing them there — still looking — maybe I am not looking in the right place... you can't believe they're not there ... disbelief ... stunned ... not being able to comprehend."

In spite of the shock and loss, "Everything we knew before was now changed." There was a new emerging feeling throughout the city, country, and world. One nurse had a call from a colleague in Romania that made her "realize how far-reaching the story is; everybody in the world was seeing this and it touched their lives as much." As one nurse said, it was a "defining moment in everyone's life but it was also a unifying moment." Another related, "People all came together, a feeling of connection throughout the whole city, a feeling of oneness, supporting each other." There was a "recharging of the spirit to see the willingness of people to help." Now the towers, the "grave of thousands," were a symbol of the power of people as caring and willing to help.

Theme two: Disaster without patients

The nurses repeatedly discussed the phenomenon that is best described as a disaster without patients. What seems to make this all the more disturbing for the nurses is that disaster preparedness was in place. A horrible disaster took place of the magnitude unheard of or experienced in the U.S. and yet there were no patients. In those early hours after the disaster there was the realization that a disaster could be so devastating that it could kill most of its victims. There was no one left to come to the hospital except for those who were part of the disaster-prepared rescue team:

We went to Chelsea pier, to the triage center, about 500 doctors and nurses, and they came from all over, we just waited and set up triage, the IVs, the tables and waited for casualties but they just didn't come.

The waiting and not knowing when and if the patients would come was very disturbing and frustrating for the nurses:

Basically what we did was we sat around or stood around looking at each other talking to each other about our feelings, our concerns, our fears, and just played the waiting game for hours and hours.

One nurse related her fears and then the realization of the magnitude of the disaster:

...that was where the frustration came, when the patients didn't come, that you realized how this is really bad. We're not getting patients, you know but you still kind of say, well, they haven't gotten to them yet. That's why we haven't gotten them. They'll get to them and when they do, we'll be busy. The hours progressed and you kind of realized, we all had this sinking feeling, that it was a lot worse than we had even imagined.

Another nurse devastated by the experience expressed the disaster as, "We were all ready but there wasn't anyone to treat because everyone was dead."

“Some nurses who were well qualified and willing to help, but who lacked the formal organization connectedness, voiced frustration with their inability to be of assistance.”

For some this disaster initially started to follow the path of overwhelming numbers of victims, (horrible burns, smoke inhalation) but then...

...we thought ...we'd be getting a tidal wave of patients. And for a while it seemed like we did. And then suddenly it stopped and there was just a small trickle of patients. Then it stopped and we were like, you know how it is when you're at a code and your adrenaline is flowing and even when you're anticipating them bringing in someone to face it and do it, do what you have to do, and that's how we felt but there was nobody else. It was the most frustrating feeling in the world. We were all geared up and ready to tackle whatever and nobody came our way.

No patients added to the surreal/unreal nature of the experience. It didn't make sense, no patients, when the two largest buildings in New York City with thousands of occupants were annihilated. Disaster preparedness means that you are ready to care for the victims of the disaster. In this case, there were no victims to care for. Several of the nurses' accounts put the magnitude in perspective, "Everything was in place by 10:30 AM. and we got one patient up until 1:30 AM. We got scared then. There was a lot of death. At that point we got the body bags." And another put it this way: "...then the buildings collapsed and they [the patients] stopped coming."

Theme three: Coordinating with and without organizations

The satisfaction or the frustrations of the nurses responding to the terrorist attack of September 11 appear significantly linked to their involvement in particular organizations before the terrorist attack. Bureaucratic structures either encouraged or hindered coordination of the nurses and their ability to be effective.

Nurses in a hospital setting expressed the professional and responsible feelings of all team members being involved in the coordi-

nation and focus of the staff. Everyone was willing to help, regardless of rank. Response from the community was encouraging but overwhelming at the same time; no one had ever tried to coordinate people from all the other hospitals and areas that had come to help. The nurses identified the need for a process to utilize those willing to help, while ensuring that no one was put at risk.

Some nurses who were well qualified and willing to help, but who lacked the formal organization connectedness, voiced frustration with their inability to be of assistance. Some nurses related that it was only through their own assertiveness, determination, and aggressiveness that they were able to provide assistance to those who needed it. "We called the hotline numbers that were published; we were told we weren't needed and it was frustrating." "This is my city." "I can't stand this [not allowed to help out]. So I got with two of my friends and said we're going down, we don't care. We're going to bypass everyone." When the nurses did get down to Ground Zero, one nurse related, "We were angry because we ran into nurses that said the same thing, 'we were told we weren't needed.' All of us, assertive and aggressive, said 'we'll take matters into our own hands.' We got in by ourselves, with either a police or fireman escort. We were working with the rescuers, those guys needed us."

The frustration of the nurses who were not part of an organization was very high. There were a lot of nurses who wanted to do something, but they felt they were being pushed aside:

Actually we needed more [nurses]. But they were being told they weren't needed. They were getting mixed messages. We ran into nurses from out-of-state, Alabama, who the Red Cross had called in. I'm saying, this is our city and we can't get there [Ground Zero]. I was very upset. It didn't make any sense. We knew the culture, the mores, how people would feel. And none of us got called

... What's wrong with that picture?

"Part of the frustration was a major lack of coordination of efforts between people and the groups that were out there [American Red Cross]." One nurse had coordinated, and scheduled over 200 nurses around the clock who were willing and able and fresh to go into Ground Zero to relieve the nurses who had been working for long periods of time with no relief. Due to the lack of paper work, the nurse was told, "Sorry, that's the way it is." Thus, "there were nurses who were tired and hungry that needed to have a break, but because of regulations [were unable]." Although they were very much needed, they had been turned away.

Nurses associated with the Red Cross and the National Guard, who went into the area with a background in disaster preparedness, did not express these same feelings of frustration. "Because I've been involved in the Red Cross and the structure and the organization for getting nurses to areas that need assistance, I think I went with the idea of what I'd be doing." "You can't just run in; you have to go through the process of the organization." One Red Cross nurse related, "We didn't need more nurses, what we needed is more nurses who are part of organized structures. You need hands but more organized." This same nurse did acknowledge that all the nurses she worked with were beneficial and helpful, saying, "You have to find something you can assist with when you're not in the organization."

Nurses belonging to disaster organizations felt they accomplished a great deal, and that many processes were in place to deal with the attack. One Red Cross nurse stated, "In my own mind if any place in America would be ready to handle this type of devastating event, it would be New York City. I feel there were some processes in place."

Nurses without this background described their frustrations and the lack of an emergency system in the city. "I was surprised that we were basically, as a city ...we were putting up an emergency station and we had nothing to work with. They were short on nurses; I was

amazed the city had no emergency systems in place.” Another nurse stated, “What scared me was that we did not have supplies. They should have a stockpile somewhere for emergencies like this.”

Theme four: Rediscovering the pride in nursing

Nurses spoke of the urgency to help, as they learned of the disaster. One nurse said, “As a nurse I had to do something. Once this all started happening we started mobilizing nurses on our own; calling to see if we could help out because the city was shut down.”

Nurses felt more fortunate than most other Americans, being in a profession that could provide tangible assistance to those in need. While many others were trying to think of ways they could help, the nurses were already in a natural position to assist. As one described, “It was just wonderful that we were able to do something and feel like we had a place to go and not just sit home and listen to the radio at the time.” Another related, “I felt lucky to be a nurse because I could help and did not have to find a way to do that.” For many nurses it was a means to rediscover pride in the profession they had chosen. Nurses who had left the bedside for other roles in the profession were re-energized in the return to providing direct support and comfort. “We felt like we were really helping. It helped us feel that we put into use what we were trained to do.” Another said, “We were able to provide comfort, hot food, emotional support for these people. That was pretty much priceless in my book.”

Nurses were intuitive in knowing who needed their care. They naturally had the ability to immediately assess the needs of the patients and their families and intervene. Nurses were in demand as a profession because of their flexibility and dedication to providing unconditional support. Nurses also demonstrated innovation by using a “kitchen microwave to heat IV fluids” and “set up IV bags of saline on poles to more easily flush eyes” of rescue workers. Nurses were needed because they, above all other professions, “know how to care.” As the recovery of patients dwindled, the focus of patient care changed to acknowledge the needs of the personnel involved in the rescue and other nursing colleagues. As one said, “You are supporting the people who are there and each other. You do some of it automatically as a nurse.”

Nurses abroad responded with faxes and phone calls in support of patients and their distressed colleagues. Nursing came forward to provide strength for patients and their families. While rediscovering their own passion for humanity and their profession, nurses were appreciated by the thousands of lives they touched during that horrible time.

Theme five: Traumatic stress

A consistent theme throughout the nurses’ interviews was the presence of stress. Whether talking about how they felt while working at the WTC disaster or about the victims they treated, signs and symptoms of stress were pervasive. The initial realization of stress was characterized by descriptions of volunteer workers, mainly firemen, policemen, and National Guardsmen in whom “shock, fear, and mourning were visible on their faces.” Firefighters were recovering body parts and putting them in bags, “the smell of death was everywhere,”

resulting in a huge psychological toll on the disaster workers. “Everyone had a dazed look...people were so overwhelmed by the sights they couldn’t speak.”

Witnessing the grief, mourning, and shock and trying to console the disaster workers was a job for the nurses working at Ground Zero. Nurses described that “experiencing the deep emotions of people” may help share in their grief and lighten their load. One nurse, a National Guardsman, did Critical Incident Stress Management with the soldiers working at Ground Zero. She recalls, “Then to see the sights he saw, the smells, just the horror of it all. The bad part is he is 23, very young, and, of course, I identified because I have children that age.” Another nurse said, “Sometimes you’ll just see someone in tears.” “When they would walk in their faces — they were tired, so upset.” Nurses admitted that they would personalize people’s stories. “You begin to identify with those people ... and you think how they remind you of people you know.” Witnessing the intense emotions of grief and mourning, shock and anger, and helping victims and disaster workers cope with these emotions fell to the nurses. Internalizing these feelings is hard to avoid and could possibly result in the vicarious traumatization of the nurses

dealing with the intense emotions and horrible devastation they experienced. One nurse described how she felt about working for many hours with other nurses and seeing such trauma. “What we had all been through ... It was almost like a horrible private little club I felt we were in.” Nurses described feeling very “terrified and upset to see their city suffer such a horrible wound.”

Nurses did their jobs and put many of their own emotions aside. They compartmentalized their feelings and kept working. “No time for anger, you’re waiting to help, wanting to help.” It was stressful for the nurses who didn’t see many patients because “there was a lot of death.” As one nurse put it, “to stand on a grave of three thousand people and not be affected” would be very difficult. Symptoms of post-traumatic stress were felt by many of the nurses. Some experienced nightmares and flashbacks of victims they cared for. Others described themselves as emotionally fragile

and being able “to cry in a New York minute.” One nurse has “a lot of pop-up fears that are triggered.” Physical symptoms of stress, such as high blood pressure, were reported less but still significantly impacted their lives. One nurse had to change her diet, exercise more, and stop reading the newspaper and listening to the news to help decrease her blood pressure. She realized that “I couldn’t leave it alone. It was affecting my health and I had to step back.”

Most nurses feel that their symptoms of stress are minor and temporary. Some participated in debriefing or counseling sessions provided by their hospitals and felt they were helpful. Most nurses however, said that they have been dealing with their feelings by “working through it” and by talking with colleagues. Putting things into perspective by talking and “constantly debriefing each other” seemed to work for most of the nurses. Talking with one’s family was not as important as talking with those who had shared the same experiences. Many nurses felt that although some used the grief counseling and groups that were offered, “Healthcare professionals are not the easi-

“While rediscovering their own passion for humanity and their profession, nurses were appreciated by the thousands of lives they touched during that horrible time.”

“The loss of an important symbol of the city was replaced with a unifying spirit of helping others.”

est ones to open up about these things.” The outpouring of support from RN’s in other states and countries and from the people in general also helped.

Advice nurses would like to give others who might be affected by a similar disaster is to talk with colleagues and to know one’s limits. It is important to take time out, “recharge your batteries and rest.” As one nurse aptly put it, “Some people go to the bar [to medicate the feelings] but you can deal with it now or deal with it later.”

Theme six: Preparation for the future

Many of the nurses discussed the need to evaluate what happened and to learn how to be better prepared for the future. Nurses who work in specialties other than emergency nursing may not be familiar with the procedure of triage in disaster situations. Triage, the sorting of patients, functions to divert valuable resources such as medical attention and supplies to the patients most likely to survive. Most medical professionals are familiar with resources being utilized for the most critically ill patients. Processes during a disaster situation function to salvage the most people, not the most ill. This “reversed care priority” is unsettling to many nurses. While the caring expertise that nurses can offer is needed in a disaster situation like the WTC event, the disaster relief agencies restrict many functions to nurses trained in the unique management of disasters. One nurse related, “You’re expected to know how to do mass casualty ... you must train for the worst and you hope for the best.”

Nurses expressed feelings about the underutilization of some nursing organizations and the need for a mandatory plan to allow nurses to respond in a time of a terrorist disaster. A need to coordinate healthcare services was identified in different areas. One was a general lack of coordination; another was frustration at the inability to coordinate the efforts of those local nurses who were willing to help with the disaster groups that were brought onto the scene. The nurses identified a need for organizations that routinely respond to disasters to allow and encourage

contingency plans that include other well-organized local groups.

The nurses who had not been a part of a disaster organization prior to the September 11 WTC terrorist attack all expressed the desire to become a member of an organized group, to seek out the training to increase their assistance, and to prevent the feelings of frustration that they experienced during this disaster. All nurses, whether involved in organizations or not, expressed a sincere need to have regular organizations in place and a need for more disaster preparedness.

The constitutive pattern: Nursing enables a humanitarian disaster response

The constitutive pattern links all related themes across texts. Nursing enables a humanitarian disaster response is the pattern that describes the overall pride in the nature and skills of nursing practice. While every nurse experienced the overwhelming loss of life in the disaster, they also experienced a unifying response. Now nursing values of human caring, of meeting the needs of victims and rescue workers, are most important. Humanistic responses during the disaster brought the people together as persons in need of each other. People of all kinds were willing to help, but the nurses possessed the skills that enabled them to respond to each situation, whether it involved the acutely injured or the emotionally traumatized.

Nursing skills in organization and leadership assisted in setting up response centers where no prior plan existed. Nurses were also capable of meeting the emotional needs of those who experienced traumatic stress. Flexibility was also seen when nurses changed focus from trauma victims to meeting the needs of rescue workers and the families who lost loved ones.

Discussion

Through interpretation of the nurses’ narratives, we comprehend what it means for nurses to personally experience the September 11 WTC disaster. We also realize the value of our nursing skills when attending to all the persons requiring our care. Therefore, when

examining the themes in relation to our preparation for future disasters, we can draw out the following:

In theme one, the loss of an important symbol of the city was replaced with a unifying spirit of helping others. Many people from around the world felt kinship with us during our time of crisis. Nurses may discover hope in the midst of tragedy.

Theme two, disaster without patients, reminds nurses to broaden their view of “victims” to include rescue workers and grieving families, as well as the critically injured. Nurses must remain open to assess the needs of all of those affected, including themselves.

Theme three, coordinating with and without organizations, reminds us that nurses, while capable of leadership and organization, are facilitated by formal organizations. Organizations such as the American Red Cross have structures in place to facilitate access to resources while ensuring the safety of workers. Nurses wishing to volunteer in the future should become members of organizations and receive training in preparation for future disasters and terrorist acts.

Theme four, rediscovering the pride in nursing, recognizes that this experience brings into focus the nursing values that society often overlooks, such as caring for others. The nursing profession prepares people to assess needs and plan interventions. Creativity and the ability to improvise are skills needed in crisis situations. Nursing focuses on the need to volunteer and help in disaster situations.

Theme five, traumatic stress, highlights the need for psychological support for all persons experiencing this disaster. PTSD and other psychological problems are predicted to be prevalent in the next 6-18 months as a result of September 11. Nurses are not immune; however, thus far, they seem to be coping. Hopefully, nurses will continue to manage their feelings and not experience PTSD. One has to wonder if feeling they were needed and had a job to do, and the fact that they did it well, will contribute to their continued well-being. Nurses working at or near Ground Zero felt the camaraderie and bonding that took place among all healthcare providers who

worked there. This, combined with the backing of the American people, will enable these nurses to maintain a sense of fulfillment and pride that has brought the nursing profession to where it is today.

Immediate appearance of PTSD symptoms was also found in victims of the World Trade Center attack (Stopford, 2001). Because these symptoms present so early, North et al. (1999) suggest that hospitals develop post-disaster screening procedures for PTSD using the symptoms of avoidance and numbing, which were present in 94% of the subjects with PTSD in her study.

In an article discussing children's reactions to traumatic events, Davidhizar and Shearer (2002) recommend actively seeking out children and families needing counseling after a disaster. Because the chance for developing PTSD after an event such as the WTC attack is so high, early intervention and counseling is encouraged. Young children need to be assured of their safety and encouraged to express themselves through creative activities or discussion. Regression to earlier developmental stages and separation anxiety may occur in

younger children, and older children may seem withdrawn or begin destructive behaviors (Davidhizar and Shearer).

Hospital and rescue workers can be especially traumatized by disasters. Critical incident stress debriefing is a tool that has been used for many years to help emergency service personnel deal with traumatic events. Debriefing gives those involved in an event a chance to confidentially discuss their emotions, clarify aspects of the event they are unclear about, and become aware of resources available to them (Rubin, 1990).

Theme six, preparation for the future, reminds us that the threat of terrorist acts and natural disasters is ongoing. Nurses need to be prepared for leadership in the field. They need knowledge of reverse triage concepts, which are necessary for proper allocation of limited resources; and they need to join and train in volunteer organizations. Additional content for nursing knowledge should be management of other terrorist techniques such as bio-terrorism. Nurses can then continue to be vital members of the healthcare team.

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New York State Nurses Association
11 Cornell Road
Latham, New York 12110-1499