

# September 11<sup>th</sup> and the Crisis Response for the Federal Courts

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**IN THE WAKE** of the terrorist attacks on September 11, 2001, the call for help went out to America from those in the public and private sectors that were directly affected by these events. Help quickly arrived in the form of money, medical and rescue personnel, and assistance from the mental health community. As a mental health crisis intervention specialist, I was one of those who responded. In addition to working with victims from the Pentagon, I also joined a response team sent to lower Manhattan at the request of the federal court in the 2<sup>nd</sup> circuit. This article describes what our team did to help the 2<sup>nd</sup> circuit and why we did it. First I will explain the crisis intervention model that we used, the reasoning behind how we formed the crisis teams, and the timing of our response. Next I will analyze the event itself, and finally, factors for managers and court staff to consider when formulating future crisis responses.

## The Crisis Intervention Model

The September 11<sup>th</sup> terrorist attacks constituted a crisis of mammoth proportions, which placed an enormous strain not only on our economic infrastructure, but on our human resources as well. By their very nature, crises can affect us on many different levels, not the least of which is our psychological well-being. Indeed, in order for an event to qualify as a "crisis," there must normally be some sense of disruption to homeostasis (one's sense of balance in life); a failure of one's usual coping mechanisms to reestablish homeostasis; and some evidence of functional impairment, such as an inability to concentrate; memory difficulties; sleep disturbances, etc. In a crisis, our usual coping skills fail to

reestablish our sense of balance and control in life; thus we can be at a loss as to where to turn for help. The crisis intervention model Critical Incident Stress Management (CISM) has evolved to become one of the leading crisis intervention models used in the world. CISM is the model that we used with the federal courts in the weeks following the terrorist attacks. Let's look in greater detail at CISM as a crisis intervention model.

CISM is a comprehensive, multi-component crisis intervention model. It is a psycho-educational model whose interventions range from the pre-crisis phase through the acute crisis phase and into the post-crisis phase (Flannery & Everly, 2000). CISM employs strategies such as one-on-one interventions, critical incident stress defusings, debriefings and demobilizations. I will define several of these interventions in more detail later. An important point to make here is that CISM is not therapy, nor is it designed to replace formal therapy. To keep CISM in its proper perspective, the following analogy may be useful: CISM is to formal therapy what emergency medical services are to formal surgery. In the medical world, prompt treatment by trained personnel of certain physical injuries may preclude the need for formal surgery later on. The same argument applies for CISM. When CISM interventions are promptly delivered by trained personnel, the need to seek formal therapy later on may be alleviated. In addition, like emergency medical services, CISM can also help facilitate the individual to the next level of care when needed. To understand CISM it may be helpful to look at it from the larger context of crisis intervention.

## Crisis Intervention

What do we mean by the term crisis intervention? Everly & Mitchell (1999) define crisis intervention as "the provision of emergency psychological care to victims as to assist those victims in returning to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma." Procedures for crisis intervention have evolved from the work of people such as Erich Lindemann (1944), who conducted studies on grieving in the aftermath of a major conflagration at a nightclub. Kardiner and Spiegel (1947) devised three basic principles in crisis work: 1) immediacy of interventions; 2) proximity to the occurrence of the event; and 3) the expectancy that the victim will return to adequate functioning. Gerald Caplan (1964) concentrated on community mental health programs that emphasized both primary and secondary prevention. While there are many models of crisis intervention, there is general agreement about the principles of crisis intervention that are employed by emergency mental health professionals. These principles are 1) to alleviate the acute distress of victims; 2) to restore independent functioning; and 3) to prevent or mitigate the aftermath of psychological trauma and post-traumatic stress disorder (PTSD) (Butcher, 1980; Everly & Mitchell, 1999; Flannery, 1998; Sandoval, 1985). Factors identified by those who have studied crisis intervention as important agents of change in crisis procedures are: ventilation and abreaction, social support and adaptive coping (Flannery, 1998; Raphael, 1986; Tehrani & Westlake, 1994; Wollmann, 1993).

Negative emotional impact is a common reaction among those who go through a traumatic event. The ability to share this impact (ventilation) with others is generally viewed as an important step in recovery. This act of sharing releases repressed emotions (abreaction) related to the traumatic event. Social support networks provide victims with information and let them know that they are not alone in their reactions to trauma. This gives victims some of the assistance that's needed to begin again. Adaptive coping involves cognitive and behavioral skills emphasizing information gathering, cognitive appraisal and skill acquisition (Flannery & Everly, 2000). CISM interventions allow for the ventilation and sharing of negative emotions, they provide the necessary social support to victims and they offer the educational components that open the door for victims to gather information, engage in cognitive re-appraisal and begin the journey of learning new skills.

Let's now explore several of these CISM interventions in more detail.

### CISM Interventions

Since this article focuses on a specific model of crisis intervention provided to the courts following the attacks of September 11, I will limit my discussion to the "group" crisis interventions of CISM. First I will discuss critical incident stress debriefing.

Viewed by many as the "capstone" of the CISM interventions, the critical incident stress debriefing is a 7-stage crisis intervention group process designed for the prevention or mitigation of post-traumatic stress. Historically, populations targeted to receive debriefings have been high-risk occupational groups such as fire suppression, law enforcement, EMS, and other public safety professions. Over time, however, debriefings as well as other CISM interventions have been adopted by the military, schools, banking, industry, airlines, and employee assistance programs (EAPs).

Critical incident stress debriefings are group meetings whose purpose is to discuss a traumatic event or a series of traumatic events. The debriefing (as well as the critical incident stress defusing) is designed to mitigate the impact of a traumatic event; prevent the subsequent development of post-traumatic stress disorder; serve as a mechanism for early identification of those in need of mental health follow-up; and facilitate those in need of follow-up to the next level of care.

The three-stage crisis intervention group process known as the critical incident stress defusing resembles the debriefing. However, while debriefings are typically conducted within 24 to 72 hours or more following a traumatic event, defusings are implemented immediately, or within 8 hours of a traumatic event. Defusings tend to be shorter in length, running approximately 45 minutes to an hour, compared to a debriefing, which usually runs an hour and a half to two hours. The defusing can be led by an experienced "peer" member of a CISM team without requiring the presence of a mental health professional. The debriefing can also be led by an experienced peer member of a CISM team; however, it should never be implemented without a mental health professional present as a member of the team. The defusing can serve several purposes: 1) to equalize information cells; 2) to try to eliminate the need for a formal debriefing; and 3) to improve the willingness of the personnel to communicate in a formal debriefing if one is necessary.

This may be a good time to briefly mention the CISM team. This team generally consists of trained mental health professionals (MHPs) and peers. The combination of MHPs and peers has proven to be very effective when dealing with groups in crisis. Peers provide a team with an immediate level of credibility that MHPs may not necessarily possess. The emphasis here is on using "trained personnel." Both peers and MHPs must receive specialized training in CISM before being activated by a CISM team. Otherwise they may not only fail to help the situation; they may even unintentionally cause harm.

With this information as background, I'll turn to the response of trained CISM teams to the courts in the southern district of New York following the terrorist attacks of September 11.

### CISM Response

The federal probation office in the southern district of New York has an active CISM team in place. Unfortunately, one of the basic tenets of CISM is that you do not provide CISM interventions to your own staff. Aside from this, because of the magnitude of the attacks, members of the probation CISM team were technically "victims" and would themselves qualify as recipients of a CISM intervention. This highlights one of the first things to determine when planning a CISM response: who the victims are. In

CISM terms, victims are typically grouped in three categories: primary, secondary, and tertiary.

Primary victims are those most directly affected by a crisis, disaster or trauma. These are the people typically thought of as the "direct victims" of the trauma. On September 11, primary victims numbered in the thousands. They included those injured by the blasts and falling debris; those in the immediate vicinity who had to run from the area to save their lives; and rescue personnel injured while assisting other victims. Typically, rescue personnel come under the "secondary" victim category. This is what makes events such as September 11 so unusual. In this event, primary rescuers became primary victims. It's a phenomenon that we've seen from time to time in other mass disaster situations, such as Hurricane Andrew in 1992. In that disaster, many police, EMS and fire suppression personnel responding to help others suffered tremendous personal loss as well.

Secondary victims are those who are in some way observers of the immediate traumatic effects that have been wrought upon the primary victims. Examples of secondary victims are emergency response personnel, rescuers, and bystanders. In our response to the courts following September 11, we treated the court personnel as secondary victims. Many of these individuals witnessed the planes colliding with the World Trade Centers as well as seeing and interacting with many of the primary victims fleeing the area.

Tertiary victims are those affected indirectly by the trauma through later exposure to the scene of the disaster/trauma or by a later exposure to primary or secondary victims. Family members of victims or rescuers might be examples of tertiary victims. September 11 took this classification of victim to a new level. There were stories of people "glued" to their television sets in the days immediately following September 11. Some people said that they could not tear themselves away from the television. I was told of an eight- or nine-year-old child walking up to the television while the parent was watching the news and turning it off. The child then told the parent, "I'm tired of this and I think you need to go outside with me!"

One of the first responsibilities in formulating a crisis response for the courts was determining who was impacted and how. Once those groupings were established, we could formulate a plan for responding; decide upon the types of interventions

needed; and determine how many teams would be called up. Doing this type of "intelligence gathering" in advance provides a tremendous service not only to the responding teams, but also to the victims. It helps to ensure that victims with similar exposure to the trauma will be grouped together, thereby minimizing the risk for secondary traumatization, that is, individuals being further traumatized by exposure to others' more intense experiences.

## The CISM Teams

Because the probation team in New York Southern was effectively taken "out of action" by virtue of their psychological proximity to the attack, an initial call went to Paul DeFelice (Chief of the U.S. Probation Office) and the CISM team from the federal probation office in the northern district of New York. Note that this was a group of federal probation officers from New York Northern responding to provide CISM intervention services for the federal probation office in New York Southern. This highlights the advantage of having a CISM team comprised of both mental health professionals and peers. The officers of the CISM team came to the southern district with "instant" credibility because they could "walk the walk" and "talk the talk." This is a great advantage in a time of crisis. Victims have repeatedly said that having members of a CISM team who know what the victims do for a living provides an instant level of comfort when involved in a group process such as a debriefing or defusing. This dynamic also helps to break down some traditional barriers that may preclude individuals from talking during one of these meetings. Thus a key component of the CISM team is that CISM is a "peer managed and peer operated support program, which utilizes mental health services personnel for their guidance and expertise" (Everly & Mitchell, 2000).

The New York Northern CISM team spent three to four days providing CISM interventions to officers and staff in the probation office in the southern district. From this intervention the request went out from Karen Milton, the Circuit Executive's office in the 2<sup>nd</sup> circuit, for a similar response for other affected court personnel. I received a call from the CISM coordinator in the southern district, U.S. probation officer Chris Porter, requesting additional CISM team(s) to respond. Two additional teams, one from the federal probation and pretrial services office in the district of Maryland and one from the

federal probation office in the western district of New York, were deployed. At the time of this request I was conducting training in New York Western, so I made the request to their chief, Joe Giacobbe, and he assigned three members of his CISM team to respond. Bill Nery, the chief of the probation and pretrial services office in Maryland, was also contacted about sending members from his CISM team. I conducted some initial assessments with personnel from the southern district on the number of affected personnel and the level of need. We decided to offer a series of critical incident stress debriefings over a period of two to three days. Realizing that attendance at these debriefings would be voluntary, we were unsure just how many court personnel would attend. Since the potential number of attendees approached 200, offering several debriefings each day over the course of two to three days seemed logical. The team from the Maryland probation office functioned as one team and I served as the mental health professional for the team from western New York. Over a three-day period we provided debriefings for over 100 court personnel. Without violating the confidentiality of those who participated in these debriefings, a detailed description of the debriefing process that we used in New York may be helpful at this time.

The critical incident stress debriefing is a group process consisting of seven phases: Introduction, Fact, Thought, Reaction, Symptom, Teaching, and Re-entry. The location for a debriefing is usually a neutral, relaxed environment, free of distractions. Participants and the CISM team sit in a circle, with the team members peppered throughout the group. The team member leading the debriefing begins by introducing him or herself and providing the ground rules for the debriefing (Introduction Phase). These rules include strict confidentiality; asking participants to speak only for themselves; advising that no one is required to talk but that talking about the experience may prove beneficial in recovering from the trauma; providing no breaks during the debriefing; and asking participants to turn off all pagers and cell phones. The leader asks participants to identify themselves and, depending on the event being debriefed, their roles during the incident or their job within the organization. As participants identify themselves, CISM team members also identify themselves (Fact Phase). The leader then asks each participant to recall their first thoughts at the beginning

of the incident or upon first learning about what had happened (Thought Phase). Next, participants are asked what was the worst part of this incident for them (Reaction Phase). This phase tends to be where the strongest emotions are shared and where the bulk of the debriefing time is spent. Throughout this time the CISM team leader does most of the talking, while other team members watch and listen to participants as they respond. However, other team members are not prevented from talking during these initial phases. In fact, they are encouraged to offer thoughts, comments and insights wherever appropriate throughout the debriefing.

Following the Reaction phase the debriefing moves to the Symptom phase. Here participants are reminded that often our bodies let us know when we are stressed. Examples of this are muscle tension, chest pain, sweaty palms, etc. Participants are asked to describe any physical symptoms they have been experiencing since the incident occurred. The Teaching phase marks the end of questioning the participants. CISM team members now begin teaching participants by sharing information on activities they can engage in over the days and weeks to follow that may help in their recovery. Next is the Re-entry phase, where participants are given an opportunity to ask any lingering questions or express any ongoing concerns. In the Re-entry phase team members offer summary comments designed to provide some sense of closure to the debriefing. Participants are told at this phase that team members will remain after the debriefing for anyone wishing to speak one-on-one with them.

A primary goal of CISM interventions is identifying reactions to a crisis as normal. Participants are reminded throughout the debriefing that their reactions are normal and that it is the event that is abnormal. An important purpose of the critical incident stress debriefing is to allow participants to see that many of their reactions are shared by others. Knowing that others understand and experience similar reactions to tragic events can be a tremendous source of comfort for victims of trauma.

I should mention that the CISM teams were not the only source of assistance available to court staff during this time. Mental health counselors associated with the contracted EAP were also on hand to provide one-on-one interventions. This is important to keep in mind because experience has shown that a multi-component approach in times of crisis

tends to provide victims with the best of all possible worlds. Some individuals who attend group crisis interventions such as the critical incident stress debriefing may feel some additional need to talk one-on-one following the debriefing. Others may only seek one-on-one assistance because they are not comfortable speaking about sensitive and emotional issues within the context of a group. This also helps to maximize the chance that more staff affected by the trauma will have the opportunity to get some assistance in a timely manner.

Let's turn now to some analysis of the unique nature of the events of September 11, before addressing some factors managers and staff can consider should they find themselves in need of planning a crisis response.

### *The Unique Nature of the September 11 Terrorist Attacks*

The terrorist attacks of September 11 presented those in the business of providing crisis intervention services with unprecedented challenges. As a crisis responder, one of my first challenges was processing the incident for myself. Of course, I later learned from many of my colleagues that I was not alone in facing this particular challenge. It could be said that we were all victims of this tragedy. The personal level of connection varied but I have yet to talk to anyone—responder, victim or observer—who did not in some manner feel traumatized by these attacks. So I and others like me were immediately faced with the task of doing some initial processing so that we could, if called upon, be ready to objectively assist those much closer to the events and far more traumatized.

Another more obvious challenge presented by September 11 was the sheer magnitude of the event. On one level we had a single event—a terrorist attack on American soil. But this attack was three-pronged—New York, Washington, D.C. and Pennsylvania. In addition we faced coordinating a response for literally thousands of people, most of whom were either primary or secondary victims. We needed a coordinated and comprehensive crisis response that would be ongoing and long-term. Even more essential was the need for planning comprehensive follow-up programs for those demonstrating a greater need for one-on-one interventions, including referrals for mental health counseling.

The events of September 11 also provided us with a challenge unlike that presented by

any other disaster in this country in recent memory. The terrorist attacks gave birth to the United States' war on terror. Even the Oklahoma City bombing, as tragic as that event was, had in effect a finite beginning and a finite end. First there was the bombing. Then suspects were identified and arrested very shortly thereafter. Ultimately there was a criminal trial and the primary perpetrator, Timothy McVeigh, was convicted, sentenced, and executed. September 11 has enjoyed no such ending. In fact, that terrorist attack has in many respects changed the way we live our lives in the United States. The war on terror is covered in the news on a daily basis. There has been talk of the war expanding to include countries other than Afghanistan. And Americans are warned on a weekly basis of the very real threat of additional terrorist attacks on our soil. For victims attempting to recover and regain a sense of normalcy in their lives, circumstances such as these may complicate the recovery process.

Finally, from the perspective of crisis intervention, the attacks of September 11 have in some ways changed how we teach about trauma. While we always discussed the potential of traumatic events to violate personal values, beliefs and assumptions, September 11 carried this teaching to a whole new level. The long-held belief that attacks of this kind couldn't happen on our home soil was shattered. The view that the United States was untouchable or invincible collapsed along with the World Trade Center on September 11. We now teach people about accepting the reality that some people in this world actually hate the United States and are willing to sacrifice their lives to see its destruction. We talk about the process of establishing a new sense of "normal" in our lives, because we will never go back to the way life was on September 10. We discuss how the events of September 11 have caused many to go through a very significant and very serious re-evaluation of their life's priorities, and that this reaction is not necessarily a bad thing.

One other adjustment to our teaching about trauma deals with the questions victims ask in the aftermath. Often after a trauma, victims are inclined to ask, "Why did this happen?" We have always counseled that the "why" question may never be answered to people's satisfaction. And as crisis interventionists, we do not attempt to provide an answer for the victims. For me, one of the real teaching points learned from September 11

is that in the aftermath of trauma, victims should be mindful of what questions they need to ask to actively contribute to their recovery. If trauma victims get caught up in a cycle of negative questioning, this can impair their recovery. Teaching about recovery in both pre- and post-incident settings presents an opportunity to help victims restore a sense of control to their lives. Each of us needs to understand that traumatic events will occur from time to time in our lives. Thus, what truly matters and determines how we recover from these incidents is the way we choose to respond. So the question moves from "Why did this happen?" to "O.K., this has happened—How am I going to respond over the short- and long-term?" Teaching individuals that they can actively choose their response to a crisis can help tremendously in giving them back that sense of control that was so violently taken away from them. This last point provides a good introduction to the final section of this article, which explores how we can help managers and staff respond to and deal with crises.

### **Guidelines for Managers and Staff**

The following are guidelines for managers and staff to consider when planning for and developing comprehensive crisis response procedures.

#### *Policy Development*

This is the first step in successfully managing most crises that affect individuals and organizations. Without adequate policies and procedures, managers will be forced to "make things up" as they go along. This approach will not bode well for the recovery process. Some general recommendations for the organization's crises policy include: a) making the policy broad enough to cover a variety of possible crises; b) spelling out roles and responsibilities; c) identifying protocols for all necessary notifications; d) listing information on emergency organizations outside of the agency; e) providing a current listing of emergency contacts for employees; f) including a provision for an anonymous reporting system by staff to management; and g) incorporating information on accessing the local Employee Assistance Program (EAP). In addition to these elements, identifying and reviewing policies of other similar agencies can also be very valuable when developing a crisis management policy.

### Pre-Incident Training

Training on the policy should be provided to all staff once the organization has developed and approved the new policy. In addition, training should be planned on a variety of crisis-related topics for managers and staff, including: 1) stress management; 2) crisis management; 3) workplace violence; 4) substance abuse recognition at the workplace; 5) suicide and suicide prevention; 6) the grief process; 7) the nature of crisis, crisis intervention and post-traumatic stress; and 8) interpersonal and crisis communication skills.

### Employee Assistance Program (EAP)

Each office should know how to access the local EAP in the event of an organizational or individual problem. In addition, EAPs should provide ongoing training to both managers and staff. Also, when contracting with an EAP, management should always check to see if the EAP can provide crisis intervention services. This should never be assumed simply on the basis of credentials. If the EAP cannot provide these services, then management should seek these services elsewhere. The International Critical Incident Stress Foundation can identify trained crisis intervention personnel in virtually any state in the U.S. If your state has a state mental health or psychological association, these may also be sources for identifying mental health professionals trained in crisis intervention.

In addition to following these recommendations, managers and staff must keep in mind the old adage that "everyone handles this stuff in their own way." The problem is that some of the ways people choose to handle the stress they experience after a traumatic event are very maladaptive. So a manager's decision to do "nothing" after something has happened is seldom a good idea. This is not to say that every situation needs a formal crisis intervention, because that is not the case either. However, it is important to pay attention to how people are responding in the immediate hours, days, and weeks following a traumatic event. Reactions to trauma generally manifest themselves in four areas:

physical, cognitive, emotional, and behavioral. Some common signs and signals of a stress reaction under the four headings can include but are not limited to:

#### Physical

chest pain  
headaches  
muscle tremors  
fainting  
difficulty breathing

#### Cognitive

confusion  
poor problem solving  
poor attention/  
decisions  
hyper-vigilance  
intrusive images

#### Emotional

fear  
panic  
denial  
anxiety  
depression

#### Behavioral

withdrawal  
antisocial acts  
change in  
social activity  
change in  
speech patterns

Again, bear in mind that the signs and signals mentioned represent a change from pre-crisis functioning. And always remember that anyone manifesting physical symptoms after a traumatic incident should be checked by a physician.

### Conclusion

The impact of the terrorist attacks of September 11 will be felt by many of us for a long time to come. Assuming that our country experiences no other significant terrorist incidents through the summer of 2002, the next significant event for victims, family survivors, and our nation will be the first-year anniversary of the attacks. The good news is that we are recovering and will continue to recover from these events. However, it may still be discomfoting for some to realize that we will never return to life as we knew it on September 10, 2001.

Over the years, much has been learned about helping victims of trauma. September 11 took our training in crisis intervention to a new level. Fortunately, we were able to apply most of the lessons we had already learned and we remained open to learning new ones. By their very nature, crises have the potential to teach us much about ourselves, our training, our level of preparedness, our coping resources, our relationships and

our resiliency. We must continue to employ these lessons in a proactive, comprehensive, and practical manner. If we succeed in doing so, we will enjoy a post-crisis quality of life that is better than before.

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