Defining and Working with the “New Normal” After 9/11 & Katrina

As this issue of JPN was being prepared, the anniversaries of two major events in our country were occurring, both of which have shaped what has become our “new normal.” This year marks the fifth anniversary of the terrorist attacks of September 11, 2001, and the first anniversary of hurricane Katrina. All of us have been exposed to stories of these tragedies and their victims, survivors, and professional responders. The anniversaries have triggered additional press and documentaries. This editorial will focus on what has become the new normal for psychiatric nurses.

No matter where psychiatric nurses practice, they routinely help people understand their problems and illnesses by defining boundaries and roles, suggesting new interpretations of events and situations, inviting participation in analyses of situations, and modeling systems thinking. In other words, psychiatric nurses provide new perspectives by offering new lenses through which to view things differently.

Personal responses to the events of 9/11 and Katrina have been colored by past experiences of disasters, relationships between survivors and victims, and the basic resources available. Psychiatric nurses did not need to be reminded that food, water, and physical safety came first. In addition, although public health may not have been their usual work orientation, psychiatric nurses realized that responding to populations of high-risk groups, rather than individuals, was needed.

Knowledge and skills needed in disaster response

Beyond the knowledge and skills noted above, psychiatric nurses working with victims and families in disaster situations also need specific knowledge about the phases of disaster, how to understand human psychological and behavioral responses (both those of clients and their own), and what comparisons might be useful (natural events versus those caused by human beings). Internet searches can quickly locate materials on these topics.

One lesson learned that stands out dramatically is that disaster responders—nurses, as well as other health care personnel—need specific knowledge and skills to be helpful at trauma scenes. Police, firefighters, physicians, nurses, and other rescue workers need to be oriented to the rules operating at the site; just “showing up” is not enough. For example, the Health Care Professionals and Relief Personnel Worker Page (https://volunteer.ccrf.hhs.gov) provides information about the ground rules regarding how people are called, deployed, and assigned at trauma sites. In addition, the Medical Reserve Corps (http://www.medicalreserv-corps.gov) is dedicated to establishing teams of volunteer medical and public health professionals to contribute on an ongoing basis and at times of need.

In natural disasters, such as hurricanes, there may be a warning period, during which planning and preparations might happen, but with terrorist acts, there is usually no warning. Since 9/11, efforts to improve surveillance and anticipate events have increased dramatically. We saw a good example of this last August, when airplanes scheduled to fly from Heathrow Airport in London to the United States were grounded because of suspected terrorism.

Another lesson is that disasters do have phases. Consequently, the work of psychiatric nurses will change as time passes. A frequently quoted manual by Zunin and Myers (2000) outlines the phases as predisaster (threat or warning), impact (heroism, taking inventory), honeymoon (high community cohesion), disillusionment (working through grief), trigger events and anniversaries, and reconstruction (a new beginning).

Flynn and Norwood (2004) pointed out that providing psychological and behavioral help for disaster victims is not a new idea but it does require continuing efforts to better understand both the risk and protective factors. Their article includes a useful chart summarizing the common responses to and long-term effects of disasters organized under the categories of physical, emotional, cognitive, behavioral, spiritual, and long-term health consequences.

The new normal

Immediately after both 9/11 and Katrina, the media used the phrase “disaster of unspeakable proportions.” What was once unspeakable is now speakable. Our new normal is to find words for what we previously experienced.
only emotionally or had relegated to
our unconscious domains.
What feels normal now is living
with a heightened awareness of our
surroundings. Many transportation
systems warn travelers to pay close at-
tention to their surroundings and urge
them to report any unusual people or
packages. Our new normal is that av-
erage citizens actively help the police
force. Although we are now encour-
gaged to celebrate diversity and respect
people of all cultures, we are also asked
to report “strange-looking people” to
bottles are water bottles, shampoo, hand
cream, and toothpaste.
What’s now normal is to question
our safety. Cell phones for children are
considered normal by parents who fear
for their children’s safety when they are
away from home.
In the past, discharging patients
from psychiatric hospitals with a 5-
day supply of medications for patients
was normal; now, because many lived
without their prescription drugs in the
post-Katrina period, consumers de-
mand supplies that last longer.

The new normal is that we under-
stand color codes for alerts. Before
9/11, the colors red, orange, yellow,
and green only referred to the moisture
condition of forests and alerted us to
take precautions when using matches
when we camped or hiked.
Our new normal includes increased
time required when we travel by air.
Closer scrutiny of carry-on luggage is
a result of the recent Heathrow event,
where common non-explosive materi-
als were to be used by the terrorists to
construct explosives by mixing them
on-board. Gone from our carry-on

“...The devastation was so great that many people
were in shock or trying to save/protect their own
families. You have to walk through the deserted
communities to really understand the enormity of this
storm. Even in areas not destroyed, living in total
darkness, hearing gunshots and then choppers all night
and seeing bands of looters patrolling, were enough to
keep you from leaving your home.”
~ Lorri Baldwin, RN, MEd, MN
Retired Director of Nursing of the New Orleans Adolescent Hospital

authorities. Vigilance is the new order
of the day.
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Forensic nurses are serving as role
models for all of us as we learn to live
with the new normal. Gaffney, Barry,
Chiocchi, and Theis (2005) had wise
words for all of us:
Perhaps more than any other spe-
cialty, forensic nurses appreciate and
successfully interact with multiple
layers of services and organizations
within the community. It involves
listening and looking for the bigger
picture…. Don’t wait for a disaster to
happen. It is then too late to search
for training courses and relief organi-
izations when the situation is chaotic.
Get trained now. Search the Internet
and find your state Disaster Medi-
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