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.medicalreservecorps.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 this past 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 attention to their surroundings and urge them to report any unusual people or packages. Our new normal is that average citizens actively help the police force. Although we are now encouraged to celebrate diversity and respect people of all cultures, we are also asked to report "strange-looking people" to authorities. Vigilance is the new order of the day.

The new normal is that we understand 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 materials were to be used by the terrorists to construct explosives by mixing them on-board. Gone from our carry-on bags 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 demand supplies that last longer.

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 specialty, 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 organizations when the situation is chaotic. Get trained now. Search the Internet and find your state Disaster Medical Assistance or Mortuary Teams (DMAT or DMORT). Learn about disaster response through FEMA [the Federal Emergency Management Agency] and the Red Cross. Integrate disaster nursing into educational programs. Participate in state and local activities and disaster drills. Stay informed and be prepared.

Photo credit: Nancy Chiocchi.

"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
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