
Terror Distress in a New York City Primary Care Sample

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Citation

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Abstract

As a result of the terrorist activities of September 11, 2001, the entire country has experienced increased stress. Coping with the events of 9/11 poses a unique challenge, as there have been frequent terror alerts issued by the government to the residents of New York City. It has also been shown that people with a previous history of childhood abuse are more likely to have difficulty coping with new traumatic events. The aim of this study was to describe a Brooklyn primary-care community's response to the ongoing terrorist threat around the two year anniversary of 9/11. This study further intended to explore the relationship between childhood abuse and current distress from the terror threat. Fifty patients waiting for medical appointments at an urban family practice clinic anonymously completed measures of their terror-related distress and childhood trauma. Analyses indicated substantial distress due to the ongoing terror threat and concomitant restriction of activity. People who reported a history of childhood abuse appear to be coping as well as people who do not report a history of abuse. Implications of the results are discussed.

INTRODUCTION

The extent of the psychological reaction to September 11, 2001 has begun to emerge in the scientific literature. A national telephone survey conducted in the days after September 11 showed that 44% of the subjects reported at least 1 stress symptom occurring "quite a bit" or "extremely". Geographic closeness to the World Trade Center was among the predictors that were significantly associated with stress reactions (Schuster, Stein & Jaycox, 2001). An early study of Manhattan residents living below 110th street found nearly 8% of people surveyed reported symptoms of PTSD. The rate was 20% for those living below Canal Street (near the World Trade Centers) (Galea, Vlahov, & Resnick, 2002).

Coping with the events of 9/11 poses a unique challenge, especially as there have been frequent terror alerts issued by the government to the residents of New York City. The current global political situation has also contributed to renewed feelings of vulnerability and increased stress (Huddy, Feldman & Capelos, 2002). This may be particularly true for the residents of Brooklyn, due to their proximity to lower Manhattan, the detection of suspected Al Qaida cells in Brooklyn, as well as a constant terror threat to the Brooklyn Bridge. It has also been shown that people with a previous history of trauma are more likely to have difficulty coping with new traumatic events (Yehuda,

Halligan & Grossman, 2001 and Breslau, 2002). This finding is particularly salient to the local community, as epidemiological evidence has indicated high rates of crime, immigration and poverty (McCall, 1999).

The aim of this study was to describe a Brooklyn primary-care community's response to the ongoing terrorist threat around the two year anniversary of 9/11. This study further intended to explore the relationship between childhood abuse and current distress from the terror threat.

METHODS

This research project and all measures were reviewed and requisite approval was provided by the Institutional Review Board prior to the recruitment of any patient. Adult patients waiting for medical appointments at an urban medical center's family practice clinic were approached and asked if they would be interested in participating in a study about people's reactions to 9/11. Approximately sixty-eight percent (55/80) of the people who were approached agreed to complete the survey. Of those who agreed to participate, 91% (50/55) returned the measures. In total, 50 subjects completed a measure of terror-related distress (Terror Distress Scale-See Appendix 1) as well as a measure of child abuse (Childhood Trauma Questionnaire (Bernstein & Fink, 1998)). All of the data was collected within the 2 month span surrounding the 2 year anniversary of 9/11.

MEASURES

Terror Distress Scale – This is an unpublished measure designed to gather information about the person’s (1) perception of the likelihood of further terrorist activity, (2) level of terror distress, (3) reactions to their psychological distress, and (4) beliefs about the efficacy of psychological treatment for terror reaction. (See Appendix 1)

The Childhood Trauma Questionnaire (CTQ) - (Bernstein & Fink, 1998)

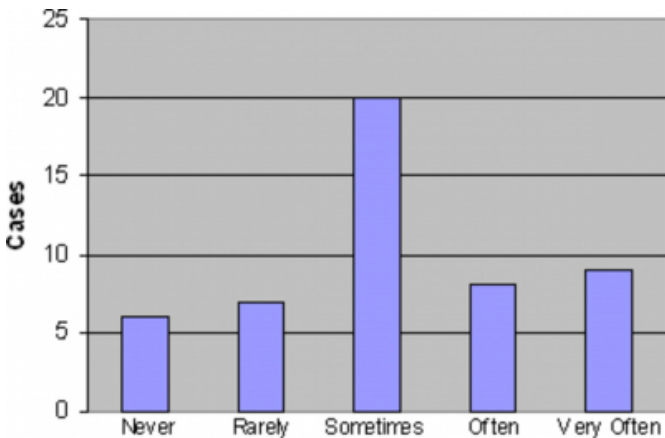
The Childhood Trauma Questionnaire is a 28-question self-report retrospective measure that has broad coverage of childhood abuse. It has been validated on a variety of populations and shown to have an overall total score and five clinical factors: emotional abuse, emotional neglect, physical abuse, physical neglect and sexual abuse. The psychometric characteristics were studied (Bernstein & Fink, 1998) and the CTQ was found to have acceptable validity, reliability, sensitivity and specificity.

RESULTS

Terror Distress – As Figure 1 shows, subjects (n=50) in our primary care population were quite distressed thinking of another attack. Seventy four percent acknowledged being in distress at least sometimes.

Figure 1

Figure 1: I am distressed thinking of another terrorist attack



Within the study population, 40% often or very often believed that they would personally be affected by another attack. Roughly a quarter of the population reported intrusive images or thoughts at least ‘sometimes’. However, despite the general distress felt by this population, only 22% reported that they have stopped doing certain activities due to the terrorist threat (i.e. traveling on the subway, going out for fun, etc.) ‘often’ or ‘very often.’ and only 8% believed

that the increased stress is affecting their health ‘often’ or ‘very often’. Conversely, 60% ‘often’ or ‘very often’ believed there are effective treatments available for the psychological reactions to the ongoing terrorist threat and many people were actively coping with their mental distress. Forty four percent of the group had done something active recently to help themselves cope, at least sometimes.

Childhood Abuse - This primary care sample mean for all types of abuse (physical abuse 8.0 ± 3.9 , physical neglect 7.7 ± 3.4 , emotional abuse 8.1 ± 4.1 , emotional neglect 9.3 ± 4.9) placed the group in the ‘none’ or ‘minimal’ categories (Bernstein, Fink & Handelsman, 1994) except for sexual abuse (7.6 ± 5.1) which was in the ‘low-moderate’ range. Within the sample two people reported moderate or severe abuse in more than two domains, while an additional five people reported moderate or severe abuse in at least one domain. This distribution is roughly comparable to the CTQ-normed HMO population (Bernstein & Fink, 1998). There was no significant Pearsonian correlation between any type of childhood abuse and elements of the terror distress scale.

DISCUSSION

This study was designed to investigate the psychological distress of a Brooklyn primary care population at around the two year anniversary of the World Trade Center attacks. Overall, the anonymous surveys indicated that many people are still being affected by the terrorism. Eighty percent of the sample was concerned that they would be directly affected by another attack at least ‘sometimes’. This high percentage seems to reflect feelings of vulnerability in addition to actual level of threat. Roughly one quarter of the sample reported that they ‘often’ or ‘very often’ have limited their activities due to the terrorist threat and a similar percentage reported continued intrusive images at least ‘sometimes’. Although these numbers indicate that the great majority of the population seems to be coping well, there is still a significant minority that is undergoing continued difficulty, as evidenced by the group of people reporting intrusive images of terrorism and of their reporting altering their daily routines due to the psychological distress. Due to the measure’s focus on distress, diagnostic estimates can not be made. However, if one were to extrapolate to the general population, then a staggering number of Brooklyn residents, a borough of roughly two million people, are experiencing enough psychological distress to have intrusive images and to limit their activity regularly.

No relationship between reports of previous childhood

trauma and terror distress was detected. Possible explanations for this finding include: (1) The study design relied on self report measurement and not clinician derived observations. Furthermore, there is no data on the people who refused to participate in the study, thus possibly subjecting all interpretations to the confounding effects of sampling bias. Finally, the relatively small number of people surveyed, might lack the sufficient power to detect an existing relationship. (2) Perhaps measuring the occurrence of childhood trauma is not sufficient for predicting future stress reactions, in that the children’s psychic response to the initial trauma might be more predictive. In a recent review of outcomes of childhood trauma, Caffo (2003) identified positive cognitive interpretation of the traumatic event as a predictor of resiliency versus PTSD. (3) It is also possible that childhood interpersonal trauma is not a risk factor for increased terror-related distress. It could be argued that since the types of threat are so drastically different, perhaps there is little cognitive carry-over between the two. However, Gray and Lombardo (2004) found that attributional styles of people with PTSD are relatively consistent across different life circumstances. (4) Finally, it is also possible that early adversity might have lead to resilience and adequate coping skills. Limitations of this study are the small sample size, the timing of the study, as the proximity to the anniversary of the attacks might over-inflate the actual ongoing distress felt by the community and the lack of inclusion of a standardized PTSD measure for comparison.

Clinical implications from this study indicate that many Brooklyn residents continue to have residual difficulties from 9/11 and the general impression that the city has ‘moved on’ is largely false. The effects of 9/11 on all patients should be explicitly explored, as it may be exacerbating their presenting problems, especially around the anniversary. Future research should continue to track New York City’s ongoing reaction to terrorism as well as further explore risk factors for the development of stress disorders.

Figure 2

Appendix 1: Terror Distress Scale

Since the terrorist activities of September 11, 2001, the United States and New York City have been on a higher security alert due to the ongoing terrorist threat. This questionnaire refers to current terrorist (Al Qaeda, Iraq, etc.) threat.

Since September 11, 2001...	Never True	Rarely True	Sometimes True	Often True	Very Often True
I am distressed thinking of another terrorist attack.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think another attack is likely in New York City.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe there are effective treatments available for treating the emotional problems people have in response to terrorist threat.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I felt I wasn't coping well enough, I would seek out help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel safe living in New York City.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am concerned that I will be directly affected by future terrorist activity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know where I could go to talk to someone about my response to the terrorist threat.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have thoughts and images of terrorist attacks that make it more difficult for me to participate in life (get work done, go out with friends, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have recently done something to help me deal more effectively with my reaction to the terrorist threat (Spoke to a friend, gone to therapy, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am upset by the current level of threat.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe the terrorists are capable of attacking the U.S. again.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have noticed that I have stopped doing certain activities due to the terrorist threats (traveling on subways or tunnels, going out for fun, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that increased stress due to the terrorist threat is affecting my health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If I choose not to speak to a counselor about my difficulties coping, it will be because _____

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