The Effects of the September 11 World Trade Center Attack on a Man With a Preexisting Mental Illness

Joy Dara Ellick, Psy.D.
Cheryl M. Paradis, Psy.D.

Research has demonstrated an association between direct exposure to traumatic events and the exacerbation of mental illness. This report describes the case of a man who had a preexisting mental illness with psychotic symptoms and no history of psychiatric hospitalization who was evacuated from the World Trade Center area after the terrorist attack of September 11, 2001. He did not receive any intensive, specialized treatment during the ensuing months as his mental state deteriorated, and he eventually required psychiatric hospitalization for a full-blown psychotic episode. Given the continuing threat of terrorist attacks, recognition of preexisting psychiatric conditions and early, specialized interventions for those at risk are essential in providing effective treatment and preventing decompensation. (*Psychiatric Services* 55:1313–1314, 2004)

Research has documented an association between trauma and the course of serious mental illness. The single case study reported here illustrates the devastating effect of the September 11, 2001, World Trade Center terrorist attack on a man with a preexisting psychotic illness. This case illustrates that, without early and specialized treatment, psychotic individuals exposed to trauma are vulnerable to an exacerbation of their psychopathology. Single case studies provide opportunities to explore issues from the unique perspective of individuals, produce data for the study of psychopathology, and stimulate the development of psychotherapeutic techniques (1).

Increased emotional responses have been associated with direct exposure to disasters and the loss of family members or friends (2). Acts of terrorism are particularly stressful because they lead to continuing uncertainty of future terrorist acts (3,4). Residents who lived in the neighborhood of the World Trade Center were surveyed immediately after September 11 and five months later; results indicated that older individuals and those who had lost family or friends showed higher distress. Half the sample developed persistent psychiatric symptoms (5). Clinicians also identified individuals who developed psychotic symptoms after heavy exposure to the media coverage of September 11 (4).

Research has shown that individuals with preexisting psychiatric disorders are more vulnerable to developing symptoms of posttraumatic stress disorder (PTSD) after experiencing trauma. A study of plane crash survivors revealed that a majority subsequently met criteria for a psychiatric disorder and that 72 percent of the survivors who met these criteria had a predisaster history of having a psychiatric disorder (6). In a study of nine individuals who developed PTSD after the 1993 World Trade Center attack, all four individuals who had a history of psychological disturbance experienced a recrudescence of these symptoms (7). A study that was conducted in New York City after September 11 noted an exacerbation of bipolar disorder, major depressive disorder, obsessive-compulsive disorder, and schizophrenia among patients (8). Resnick and colleagues (9), in their study of lifetime trauma among 47 persons with schizophrenia, found that trauma severity was associated with intensity of emotional distress and severity of PTSD.

Mr. B was a 38-year-old, African-American, married man with no history of psychiatric hospitalization. His mother and one sibling had been given a diagnosis of schizophrenia. Before September 11, Mr. B expressed beliefs that he was Jesus Christ, that appliances in his home were tapped, and that law enforcement officials were following him. Family members reported that Mr. B's psychotic symptoms had never interfered with his ability to work and that he had worked consistently since graduating from high school.

On September 11 Mr. B was working as a clerk in a large company in the vicinity of the World Trade Center. He recalled that after the first plane hit he assumed a leadership role by advising coworkers to leave the building and advising bystanders who were outside to evacuate the area. Several days after the attack his supervisor referred him to the employee assistance program because he was dressed in bizarre clothing and displayed disorganized behavior. He repeatedly stated that the world was ending and described his intended mission to "save the

Dr. Ellick is affiliated with the department of psychology at Napa State Hospital, 2100 Napa Vallejo Highway, Program 2, Napa, California 94558 (e-mail, jdara73@aol.com). Dr. Paradis is with the Health Sciences Center at the State University of New York in Brooklyn and with Marymount Manhattan College in New York City.

world" by solving numerical codes and assisting prominent political figures.

During the next several months Mr. B drank more alcohol than usual, stopped eating regularly, and experienced insomnia. His preoccupation with the terrorist attacks was noticeable. His mood was fearful, sad, and angry, and he was observed laughing and cursing to himself. Although he attended several counseling sessions, the severity of his mental decompensation was not recognized, and he was not referred for psychiatric assessment or for specialized treatment for PTSD.

Mr. B continued to work full-time until six months after September 11 when he was brought to the emergency department by police after he disrobed in public. Mr. B was then admitted to an inpatient psychiatric unit. His delusions extended beyond the local terrorist attack in New York to political unrest abroad. He displayed pressured speech and illogical thinking and experienced auditory hallucinations.

A computed tomography scan of Mr. B's head was negative. His level of overall cognitive functioning was determined to be in the low average range. His valid Minnesota Multiphasic Personality Inventory–2 (MMPI-2) profile showed elevations on scales 8 (schizophrenia), 9 (mania), and 6 (paranoia) (10). His PK Scale score (posttraumatic stress disorder) was not elevated, and no clinically significant signs of anxiety were found on the MMPI-2 (10). Rorschach projective testing showed significant psychotic thinking, and Thematic Apperception Test responses yielded stories with themes of anxiety, fear, and safety related to his September 11 trauma. Staff gave him a diagnosis of schizoaffective disorder and a prescription for 2 mg of risperidone twice daily and 500 mg of divalproex sodium twice daily. Mr. B's hospital chart did not include a diagnosis of PTSD, and it was likely overlooked. Psychological testing also did not confirm a diagnosis of PTSD. However, aspects of Mr. B's clinical presentation indicated that he had significant symptoms associated with PTSD. He exhibited recurrent and distressing recollections of the attack, increased arousal (that is, difficulty concentrating and hypervigilance), and feelings of estrangement from others.

His assessment and treatment focused on stabilizing acute psychotic symptoms, which is characteristic of the type of treatment that is typically provided in medically focused, large municipal hospitals. Traditional treatment approaches were effective in lessening his psychotic symptoms. Although Mr. B did not participate in a formal PTSD treatment program, the primary therapist addressed his complex diagnostic picture, specifically addressing symptoms of PTSD as they related to the psychotic disorder. Components of cognitive-behavioral treatment for PTSD were incorporated into his individual psychotherapy. He was encouraged to repeatedly describe his September 11 experiences in detail and to examine his thoughts and feelings associated with the trauma. Mr. B gradually became less anxious when discussing the trauma and less focused on his mission to save the world. His thinking became more organized, and his mood became less agitated, anxious, and fearful. He was discharged after 42 days and enrolled in a day treatment program.

A limitation of this case illustration is that Mr. B's diagnosis was not confirmed by administering the Diagnostic Interview Schedule or assessment questionnaires. Although clinically it was clear that his psychotic symptoms had resolved and his anxiety had lessened, posttreatment testing was not conducted to verify the clinical improvements. This case demonstrates how, without immediate interventions for those recognized to be at risk, a vulnerable individual can severely decompensate. Mr. B was directly traumatized by the terrorist attack. In the following weeks he was exposed to additional trauma by watching extensive disaster-related television programs and moving frequently from one job site to another. Although he had experienced psychotic symptoms before September 11, the trauma precipitated a full-blown psychotic episode that required his first psychiatric hospitalization. Most likely, hospitalization could have been averted if specialized treatment had been provided quickly after the trauma.

This case illustration is particularly relevant to triage trauma workers and clinicians who serve populations with serious and persistent mental illness who may be additionally traumatized by terrorist acts. The acute and long-term threat of terrorist acts may lead to exacerbations or relapse among individuals who are prone to psychiatric illness. Clinicians who provide services to those affected by terrorism need to be especially alert to victims with preexisting emotional problems, who are less resilient and more likely to develop severe symptoms if traumatized either directly or indirectly—for example, through repeated viewing of disaster-related images on television. Researchers have noted that PTSD symptoms may be missed among individuals with psychosis (9). Crisis triage workers should pay particular attention to these individuals and provide immediate antipsychotic treatment. Given the ongoing threat of terrorism, further research and training on immediate interventions for trauma are necessary. ♦

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