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Continuing Psychological Aftermath of 9/11: A POPPA Experience and Critical Incident Stress Debriefing Revisited

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Volunteer clinical experiences as part of the New York Police Department's Police Organization Providing Peer Assistance (POPPA) program are described in providing critical incident stress debriefings (CISD) to NYC emergency rescue personnel. Also, there is a discussion of distinctive aspects of September 11th that both characterize and confound a successful post-9/11 recovery, to include the intertwining of personal and national reactions to global terrorism and socio-political forces. Such factors, along with concerns about the efficacy of "one-shot clinical interventions," form the rationale for a "Phase 2 CISD intervention model" that is described.

KEY WORDS: 9/11, Critical Incident Stress Debriefing (CISD), terrorism, emergency mental health, POPPA.

Prior to the September 11, 2001 attacks committed by terrorists against American civilization, the Twin Towers of the World Trade Center (WTC) formed a structural metaphor in the psyche of New Yorkers. They served as an anchor, not just in the substratum, but also in the consciousness of those who lived and worked and played in their shadow. The towers were magnificent, elegantly framing the skyline of Manhattan. The void created by their absence has caused a festering wound in the survivors of the events of 9/11; not only to the hearts, minds, and memories of New York City dwellers, but also to millions of people in the U.S. and abroad. To take one of our cherished structures in one of our most important cities in America, and demolish it within a time frame of hours, is no less than alarming and horrifying. Add to that, the simultaneous attacks against the Pentagon in Washington, D.C., as well as the commercial jetliner that crashed into an open field in Shanksville, Pennsylvania, places us face to face with what previously was unthinkable and beyond comprehension. The total loss of 3,031 lives at all three sites (Hampson, 2002a), a result of four major U.S. commercial airliners hijacked and used as weapons of mass destruction, was a beyond-belief catastrophic loss of life resulting from this terror tactic against innocent U.S. citizens. For the untold numbers of the millions of people directly and indirectly affected by these sadistic acts, their worlds have been profoundly impacted and altered, and probably forever. Life for many of us as we once knew it is over, and will never be as it once was.

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> [Survivor of the September 11th attack on the Pentagon] *A year later, I still look up whenever I hear an airplane, not knowing what to expect. In December, I flew to Brazil to spend New Year's Day on the beach with friends. I felt safer on that flight than I do walking across the center courtyard of the Pentagon.* (Polk, 2002).

The devastation is unforgettable. Ground Zero at the WTC was reduced to a 16-acre pit of consecrated ground, where thousands lost their lives on that dreadful day. Family members grieve over their losses, exacerbated by the fact that their loved ones could not be found, rescue workers experienced frustration and helplessness because little could be done to save lives, and police and firefighters pine for the loss of their brothers and sisters. For the first and second responders, and all phases of rescue workers, only time can reveal the severity of the psychological injuries incurred and the shorter-and longer-range impact. These unsettling sets of circumstances leave much room for unfinished business, and the need for therapeutic counsel.

On the other hand, there are previous unrivaled lessons learned about the strength and character of both survivors and the various phases of rescue workers. How one is able not only to endure the unendurable, and to even find elements of tremendous insight and solace as part of the longer-term recovery process, is a tandem phenomenon to the 9/11 trauma that offers a degree of hope and resolution.

Continuing Post-9/11 Traumatic Reactions

Reliable statistical data is minimal concerning the extent and severity of continuing negative, if not traumatic post-9/11 reactions. There are descriptions of increases in both drug prescriptions among an elderly population (Austin, Mamdani, Jaakkimainen & Hux, 2002) and utilization of mental health services (Boscarino, Glea, Ahern, Resnick & Vlahov, 2002) following September 11th, and acute physiological responses during the week of September 11th (Lampert, Baron, McPherson & Lee, 2002). And a nationwide longitudinal study of psychological responses to September 11th has been initiated that hopefully will provide the basis for an empirical description of longer-term psychological responses (Silver, Holman, McIntosh, Poulin & Gil Rivas, 2002).

To date, the most prevalent data includes numerous descriptive and more subjective media accounts and the counseling experiences of the authors and many other mental health clinicians, as well as accounts describing marked resolution of personal hurt among a number of survivors and witnesses, to indicate that there is a range of severity of negative impact. Please note that the following quotes from debriefers and survivors of the WTC have been edited to delete possible identifying information so as to protect their confidentiality.

Many of the survivors of the WTC attacks have become wary of terrorism, yet further devastated by financial ruin. Life in New York City has changed more so than anyplace else, as nearby businesses closed for months after the attack or suffered precipitous declines in productivity or went out of business. Indeed, since September 11, bankruptcies in Manhattan

have doubled (Hampton, 2002). Marriages and life partnerships were, and continue to be, tested to the limits due to the relentless burdens on rescue workers during the recovery effort. A school department study concluded that about 75,000 of 1.1 million NYC students are suffering from post-traumatic stress syndrome (Hampton, 2002).

Many who directly witnessed the events of September 11th, who live and work in the five boroughs of New York City, have also been dazed by this unparalleled event. Their senses are likely singed forever with the memory of that horrible day. A number of survivors have said:

I am stuck in my 9/11 nightmares. I just can't move on!

Perhaps what they witnessed is what they will re-live, as if they were experiencing these same horrific events day after day:

- City bells ringing innocently during a normal day's activity since 9/11 may readily trigger the memories of survivor's back to the relentless chirping and wailing of alarms, which signified downed firefighters on that dreaded day. For untold numbers of NYC residents, this may be a compelling trigger for survivor guilt.

- Aircraft flying over New York air space certainly have the potential to elicit a startle response among the masses.

- Auditory memory of the buildings collapsing perhaps may be replicated by the daily volume of loud New York City noises since 9/11.

Before 9/ll, I was a free-spirited, out-going person. A year later, I experience an emotional roller-coaster ride that entails bouts of depression and fears of loud noises, airplanes and tall buildings . . . Sure I'm grateful I was spared, but many people don't live with the graphic images I witnessed as I made my way out of the Trade Center. Thoughts of burning flesh haunt me daily. (Carlisle, 2002)

As described during CISD interventions and in other clinical contacts, a number of survivors have been consumed with self-blame and guilt for not having rushed headlong back into the crashing towers to rescue those in peril.

I should have gone back to help others, but I kept running away from the building instead.

I feel guilty because all I did was direct traffic, and watch the equipment and trucks. I should have done more.

There is also a range of continuing reactions that can result: rage, confusion, and fear about the apparent random nature of those who survived and those who did not survive. Some

survivor's may have serious issues related to their belief in a God or higher power, and how a tragedy of such epic proportions could have been perpetrated. As mentioned by a number of persons in the aftermath of 9/11:

Why did God let this happen to out innocent people? Where was he?

Such a multiplicity and layering of reactions contributes to a profound ambivalence among many as to what the next steps might be. When one comes to the inevitable and full realization that it is *impossible to forget the unforgettable*, combined with the conviction that what happened should never be forgotten, *what is one to do with this experience both personally and clinically?*

What was Done: The POPPA CISD Program

The New York Police Department (NYPD) Police Organization Providing Peer Assistance (POPPA) program was a peer-driven group of police officers. POPPA organized the provision of Critical Incident Stress Debriefing (CISD) to all NYPD uniformed men and women, and any other interested rescue workers involved in the 9/11 cleanup operations. Concurrently, national and international CISD trained peers (police officers e.g., co-author Colon), and other volunteers (e.g., mental health professionals such as co-authors Viola and Platoni) traveled to New York City, rotating weekly, to aid in the POPPA CISD program. These uniformed and civilian CISD teams were trained to debrief traumatic incidents, one such as the WTC disaster of 9/11. Approximately 4000 uniformed NYPD members, both men and women, received CISD debriefings. The sessions were held at their designated headquarters in a free-standing building that was easily accessible and stationary for the eight months that followed 9/11, thus eliminating the potential for "hit and run" treatment.

While not claiming to represent what the many volunteers did who participated in the POPPA program, the authors' experiences are an example of how CISD interventions were implemented and what was shared and processed by the participants as they struggled to promote their personal recovery from the impact of 9/11. At least four distinct types of interventions were provided by POPPA: (1) consultation to uniformed peer leaders, (2) ad hoc individual informal or formal counseling, (3) formal briefing prior to CISD intervention, and (4) formal CISD interventions with various groups of uniformed personnel.

Over the course of the week, the authors co-facilitated approximately 8-10 CISD sessions. The number of participants in each CISD session ranged from 5 – 10 individuals. The intent was to help alleviate stress of uniformed individuals who witnessed and worked day in and day out due to the 9/11 disaster, to educate them about signs and symptoms of post-trauma (e.g., reliving experiences, nightmares, withdrawal, depression, hyper-startle response, anger/rage, avoidance, survivor guilt, etc.), and what to do if these symptoms occur or continue to occur post-debriefing.

Part of the debriefing protocols included psycho-educational information related to critical incidents and their impact; for example, critical incidents are typically sudden, powerful

events outside the range of ordinary human experiences. There is likely to be a powerful response within those individuals who work in an arena where critical incidents readily occur (e.g., rescue workers, police officers, firefighters, paramedics, civil and uniformed and military personnel, etc.). In scenarios where the likelihood of these events will be sudden and unpredictable, these individuals may very well experience overwhelming emotional and cognitive reactions, as was described by 9/11 survivors:

> *They just came in and took us by surprise, without any warning. We didn't expect it, and we are angry to think that someone would even compare it to Pearl Harbor.*
>
> *The military expect to die because they are at war . . . we were innocent, and not at war!*
>
> *They just went to work in an office building!*

Many times, individuals who experience critical incidents do not have the opportunity or are reluctant to speak about the event(s) to trained personnel. They may fear reprisal (e.g. loss of job, dismissal, removal of firearms, declaration of unfit for duty status, etc.) if they do admit to symptomatic occurrences. and/or lingering and prolonged feelings of shame, guilt, bewilderment, or any other forms of strong and problematic reactions. As one emergency responder said:

> *If I talk about this, or if I need medicine, that might interfere with my career!*

Others may hold back because of lingering and prolonged feelings of shame, guilt, bewilderment or other forms of strong and problematic reactions, to include preoccupation with not wanting to be looked down upon by one's peers. One debriefing observation:

> *Some officers would come in with their partners, and you could not single him out in the CISD session or even outside the room where others could see you; there was there this concern that they could be stigmatized or that their confidentiality would be broken.*

Thus, there may be a strong reluctance to seek treatment, resulting in an ever-increasing potential for the development of such *DSM-IV-TR* (APA, 2000) psychiatric disorders as Posttraumatic Stress Disorder (PTSD), Major Depressive Disorders, or suicidal thoughts or impulses. Self-medication with alcohol or other substances (illicit, recreational, or prescription) can become a dangerous and risky avenue for temporary relief of symptoms. Such behaviors can lead to future problems overlaid on top of the unresolved psychological wounds stemming from the events of 9/11.

Versions of the classically-described CISD process (Mitchell, 1983; Mitchell & Dyregrov, 1993; Bell, 1995) were implemented through the POPPA program. Participants were "walked through" a series of discussion points about what happened. They were encouraged to share their thoughts with one another about what occurred during and after the event, discussing

the worst aspect and images of the event, the presenting symptoms, and a productive way to manage at the present time. In this way, there was a provision of a supportive forum to accomplish several objectives, as illustrated by the authors' debriefing experiences in NYC.

Firstly, the opportunity was provided to ventilate unexpressed emotions:

I couldn't believe it when I saw the first tower going down . . . we ran like hell to get away from the billows of white clouds rolling down the street". I felt glad that I was safe, but felt so guilty at the same time.

Secondly, participants were enabled to come to the very powerful realization that one is not alone with their reactions to disaster and tragedy:

I guess I was afraid to admit that I was glad to be safe . . . but now I know others experienced the same thoughts.

Thirdly, the CISD forum helped participants to clarify confusions or distortions in their memories:

I should have run back into the building to save others. You could see them falling from the sky, and I just ran the other way.

Fourthly, through the sharing of personal stories of what they had been exposed to, participants were able to obtain a more complete picture of the range and depth of experiences, their impact upon various survivors, and what effects each of them experienced in the aftermath of these events.

It was unbelievable that I found an intact WTC employee lunch under the ash during our rescue operations. The land-fill was scary. Who knew what you could get as far as contamination is concerned, but what does this preserved lunch mean?

Is a "One-Shot" CISD Intervention Sufficient? What More to do?

In addition to the first phase of CISD interventions that has been accomplished in the aftermath of 9/11, the critical question is whether a "one shot intervention" is adequate or sufficient? Is there more to do in order to further promote resolution and healing among WTC rescue workers, or for that matter, in lieu of the likelihood of future catastrophic events? The question that is ever-present in the locker rooms of uniformed emergency personnel around NYC is not "if", but:

When are they going to attack again?

The POPPA program offered the advantage over typical CISD interventions in that there was an on-going resource that could be accessed by uniformed members.

Cops would return later as they developed problems to get a referral to a mental health professional. We even had retired members come back to the center. They had been debriefed when they were active members of the department, and as they developed problems they came in for help. Such cases needed follow-up to be done. This is where the CISD feel short.

It is important to note that there is a hotly debated issue as to whether typical one-shot CISD-type interventions, even those that are several hours in length and conducted within 72 hours of the event, are sufficient to resolve or ameliorate post-traumatic impact of exposure to a variety of traumatic events (Avery & Orner, 1998; Avery, King, Bretherton & Orner, 1999; Mitchell & Everly, 1999). Research studies have been presented on both sides of this issue, although many of the cited research findings have significant methodological limitations.

It is the authors' impression that, in considering all existing data from the literature and from the extensive clinical experience of mental health debriefers, that initial CISD interventions can be quite helpful to a number of those participating in such debriefings. Such certainly was the case in NYC, least in terms of subjective impressions.

When cops would come in to the center, there was high anxiety on their faces. They had no idea what was going to happen or what the CISD process was. Then, as we gave them the initial orientation and educational piece about the CISD process, the anxiety and stress level in their faces dropped. When they entered the debriefing rooms, there was still anticipation of the unknown. However, when the process was over, they could come out and talk to their peers and to the MHP. They would smile more and wanted to stay and talk with the CISD team. That in itself is a big plus and a great sign that they got something out of the session.

However, it also was clear that there were participants who did not appear to derive much benefit from the CISD interventions. Much is yet to be known regarding what factors characterize participants who evidence positive outcomes from CISD interventions versus those who seem to have not been impacted by participation in such interventions. On the other hand, the authors' have not observed or been privy to data that offers any compelling evidence that participation in CISD interventions is associated with a *negative* outcome.

The authors' are aware of at least some uniformed personnel who participated in CISD interventions and continue to manifest significant concerns related to post 9-11 coping. Continuing rage is one common manifestation:

I was angry and resentful that the terrorists took away my favorite place to entertain my family. I really wanted to look for a fight, just so I could strike out at them

While not systematically derived empirical data, the many media accounts and the clinical and personal impressions of the authors support the impression that there still is continuing and significant post-traumatic healing to be accomplished among an untold number of persons directly and indirectly impacted by 9/11.

A Phase II CISD Intervention Model

Rationale

There are factors distinctive to the trauma of 9/11 that the authors consider important to support the recommendation that a distinctively designed "CISD Phase II" should be implemented. Clearly, the post-9/11 recovery for a number of survivors is compounded by the fact that for many Americans, terrorist behaviors "against innocent civilians" are as unfathomable as eating french fries without ketchup. Such cognitive dissonance is further complicated by the specter, as terrorism experts concur, that there is a very high, if not an inevitable likelihood of future terrorist attacks on Americans and in America. Hence, a number of Americans are preoccupied with the concern that they and we are vulnerable to yet additional acts of terrorism. As was heard repeatedly during debriefings,

Who and when are they going to attack next?

Also, there is the unprecedented, massive media, political and community attention to the anniversary of 9/11. Such attention can be very positive and serves as a continuing acknowledgment of the innumerable acts of heroism that occurred, as well as the testimony to the personal and collective strength of individuals, communities and our nation to preserve. On the other hand, for other survivors such attention serves as a seemingly inescapable and recurring negative reminder about losses or increased vulnerabilities; there is a consequent exacerbation of grief, rage and other related reactions that have yet to be satiated. It is one thing to have "personal" anniversary reminders about past tragic events that may be positive and/or negative; it is quite another to have massive and inescapable anniversary reminders that literally force renewed memories to the surface for those survivors who would much rather not be reminded.

> *Let's not force families to re-live the pain . . . Each year on this date, we should not have to see the crash or re-live those moments over and over in the media . . . and over again on the T.V.* (Reddick, 2002).

But for issues related to 9/11, *avoiding such reminders is <u>not</u> a realistic option*! Unfortunately, we have no way of knowing how much it is a positive and/or a re-traumatizing factor to various individuals to have to continually be exposed to such a magnitude of unprecedented and recurring national and community anniversary reminders. However, the law of averages alone dictates that we clearly must recognize that there are and will be a number of persons who will be *negatively* impacted by such exposure (Scurfield, 2002a).

Therefore, it is the authors' conviction that there needs to be a second phase of CISD intervention for at least some and possibly many survivors. CISD can be a wonderful first start; however, there is no compelling data to prove that one-shot CISD interventions are the answer for all survivors of any trauma. Also, there are specific issues related to the distinctive nature of 9/11, and its impact, that *cannot possibly* have been addressed to any significant degree in any one-shot CISD interventions. These distinctive aspects are the primary focus of the recommended Phase II CISD model as described herein: reactions to the social and political aspects of the terrorist acts of 9/11, and utilizing the technique of cognitive reframing to help address continuing self-destructive reactions to the disaster.

On-going contact with emergency workers reveals that many of these workers continue to be full of rage and bitterness toward the terrorist perpetrators, and anyone associated with them. Indeed, the difficulty in attempting to address and hopefully reduce irrational anger and rage reactions is complicated when it can be fueled by politicians and sectors of the community-at-large who might provoke, prolong or exacerbate such reactions in the fervor to enlist support for mounting continuing world-wide campaigns against terrorist cells and to justify pre-emptive military strikes. Thus, *to even attempt* to broach this subject with the survivors is likely to be responded to with very heavy emotions of anger if not rage by a number of people being debriefed. One POPPA debriefer stated:

> *I understand the reason for offering cognitive information about how continued rage and bitterness towards the terrorists and their supporters can be quite harmful to WTC survivors. But it might be playing with a loaded gun to open that door; the reaction might be extreme anger on the part of the cops.*

This cautionary note, of course, illustrates exactly why a discussion of this cognitive information *is* so vital to the process of helping at least some of the survivors to address personal issues of extreme rage and bitterness, and why the *when* and *how* such information will be provided is so critical.

Scheduling and Timing of the Phase II CISD Intervention

There would seem to be two primary alternative strategies to achieve a second phase of CISD intervention: One alternative is to offer a second debriefing following a short break after the initial CISD intervention. This alternative offers the logistical advantage of having people already gathered together and accessible. On the other hand, typical initial CISD interventions can take from two to more than three hours, depending on the number of participants and debriefers. To elongate such an initial intervention session to include yet a further session could well be emotional and information overload for many of the participants; however, it still may have to be conducted at that time because of the logistical considerations.

The alternative scheduling strategy is for an entirely separate second CISD intervention that is scheduled days, weeks or even months later. Almost certainly, this strategy will not be able to involve all or perhaps not even most of the persons who participated in the initial CISD,

and it will require significant effort to organize and implement. In addition, there is the risk that continuing provision of CISD interventions might contribute to otherwise "hardy" groups of emergency workers becoming somewhat dependent on services provided by contract traumatologists----and vice versa. On the other hand, there is a time when scheduling such a phase II CISD may be easiest to achieve: around the time of the yearly anniversary dates of 9/11. This is in recognition of the powerful psychological impact of anniversary dates for survivors of various types of trauma. And, in the case of the 9/11 anniversary date, this is a particularly wide-spread and potent annual reminder due to the massive national media focus that is likely to continue to reoccur yearly around the time of September 11.

In addition, having one or more follow-up CISD interventions anchored to upcoming anniversary dates offers significant advantages. Firstly, there is the possibility that the massive media coverage will trigger underlying emotions and issues to where an opportunity is presented to re-look at the continuing impact of 9/11. Secondly, there is the possibility of being able to address *longer-standing* or *re-emerging* issues that could not possibly be addressed in an initial CISD intervention within 72 hours of the initial trauma. Thirdly, there are a number of profound issues distinctive to 9/11 and global terrorism that time constraints alone do not permit any significant focus on in an initial and early CISD intervention. Indeed, the depth and complexity of the distinctive issues as described are such that more than one Phase 2 CISD or follow-up sessions may be required.

The Focus of Phase II CISD Interventions

There are two overall content areas to consider focusing on in Phase II: distinctive factors related to large-scale terrorist acts, and stress reduction and coping strategies to better deal with prolonged or exacerbated post-9/11 reactions.

Perhaps the biggest question posed by survivors, heard over and again during debriefings, was:

Why would they do this to our innocent people?"

This is where an individual can become "trapped" in the trauma. Thus, resolution may not easily be reached or even possible---- especially in the acute phase of a very time-limited and typical CISD intervention. Necessary resolution relates to the critical need for further explanation and discussion of global terrorism in the context of the realities and world-view of many citizens of third world countries. Such a discussion involves both the provision of cognitive information and the processing of accompanying emotions. This is necessary in order to promote processing of continuing thoughts and emotions if survivors are to be able to "make any sense" out of what happened---and what may happen again and again. Otherwise, one may become inundated and entrenched in bitterness and hatred to the point that further healing and resolution is not only impossible, but that any gains made may be short-lived.

Clearly, the vast majority of people in the U.S. (and many others internationally) had an abhorrent reaction to the catastrophic nature of the terrorist acts-acts that in a few hours incurred about 5% of the number of deaths of U.S. personnel during the 10 years of the Vietnam War.

> *This was an extremely immoral act. How could anyone perpetrate such horror onto other innocent human beings!? (Scurfield, 2002a)*

In terms of the provision of cognitive information, there are a number of very hard working, intelligent uniformed and non-uniformed individuals----not only civil servants, but also military----who serve our country both homeland, and afar, who are not fully aware of the international cultural influences, and differences, and how these factors impact our society and our national psyche. Understanding the fanatical, cultural behavior of the terrorist must be connected to a further understanding of how one's personal reaction's to such terrorism may exacerbate or prolong continuing negative emotional reactions and self-inciting emotions (Scurfield, 2002a).

> *What is wrong with them? Why do they hate us?*

Only then is it possible to effectively address the irrational or emotional aspects necessary to enhance healing concerning this (and any future) terrorist act. Survivors may otherwise become consumed with hatred, contaminating their entire outlook. At this point, we may predict that hate-filled attitudes and behaviors will fester, like a cancer, eating away at our very morality and humanity, fueled by fear or righteous revenge (Scurfield, 2002a). To put it another way, survivors must be assisted to understand that to retain hatred will ultimately insure that the terrorists "won"---because hatred will be more harmful to the carrier than it could ever be to the terrorist or perpetrator.

The specter of such a continuing manifestation of ultimately self-destructive emotions is compounded by the need to develop positive thinking and other coping strategies in the face of future incidents. However, successful integration of positive coping will be confounded to the degree to which there is a fixation and preoccupation of one's cognitions and personal emotions about terrorists, negative generalizations about "Middle Easterners", "all Moslems", etc., and a consequent fueling of ethnic and cultural hatred. Such a focus would seem to be a critical objective for a succeeding (second) CISD phase. How can this be accomplished?

Provision of a historical and cultural context regarding war versus civilian devastation resulting from terrorism. The question concerning many 9/11 survivors involves the despicable acts inflicted upon innocent Americans, and how the tenets of a culture and religion could and would be interpreted and used as justification to perform such acts of terrorism? It is equally inconceivable to Americans how exceedingly harsh, if not impoverished, life is in many Third World countries. Women are subjugated as second-class citizens bereft of the opportunities and quality of life that many Americans take for granted, and innocent people are oppressed,

incarcerated or even killed. Such actions occur with no protections of due process and at the whim of despots, fanatical in their beliefs and their conviction that their way is right and just and indeed, moral.

What does understanding the cultures and beliefs of Third World countries have to do with 9/11? In order to heal our wounds from this unprecedented attack on innocent Americans, to avoid becoming absorbed in "it's not fair" thinking, and to prevent hatred stemming from reprehensible deeds, we must be able to apply rational thinking to the justification of any means of violence against nebulous targets. This is difficult for many Americans, who are often accused by many other countries of living on an island of denial about the realities of what happens as a matter of course in other cultures.

> *"America joined the world today (9/11). We've been living in Disneyland so long". (Cauchon* & Driscoll, 2001).

A Phase II CISD intervention would help participants to understand and discuss how the terrorist acts of 9/11 are only the latest in a series of behaviors and a morality evidenced in relatively recent wars that have seemed incomprehensible to many Americans when viewed through our cultural and moral lenses.

- During Operation Desert Storm, military service members were exposed to many elements of danger such as the oil well fires, depleted uranium, scud missiles, and bio-chemical warfare, to mention only a few. These elements would be sufficiently monumental for any individual to endure, even when expected. Issues of cultural differences, however, and attempting to understand an accept how national leaders could be allowed to starve their civilian population to death and to murder them with biological weapons en masse, are very difficult for many Americans to comprehend.

- In Bosnia, peacekeeping forces were placed in the very difficult position of being juxtaposed between warring factions who had a history of centuries of simmering ethnic and religiously-based hatreds. Consequently, peacekeepers were exposed to massive and repeated acts of violence, to include untold numbers of rapes and murders committed to justify "ethnic cleansing" and the assassination of millions of innocent peoples. And what was the personal impact upon our peace-keepers exposed to such atrocities?

- In Somalia, abject poverty and war-lord mentality confronted our soldiers with appalling acts of perceived evil that many U.S. soldiers were emotionally unprepared to deal with. A Somalian mother, in desperate need of food for her family, deliberately sacrificed one of her children by purposefully pushing the child into the path of an oncoming military vehicle in order to collect money for the death of her child. This was disturbing, unforeseen, and inexplicable conduct for Americans previously not exposed to such abject conditions and behaviors.

- In Haiti, it would not be abnormal for the local citizenry to openly bludgeon to death one of their own, in the middle of town, for stealing a chicken. American military police were attacked during one such incident, while attempting to rescue the victim. Such acts were unpalatable to American service men and women.

- In Vietnam, our servicemen and women also were exposed to countless, seemingly senseless and shocking incidents. It was not unheard of for local Vietnamese civilians to service American soldiers as friendly barbers in military base camps during the day, and to serve as furtive Viet-cong adversaries at night. This included engaging in grotesque terror tactics against Vietnamese villagers in order to frighten them against supporting the Americans. Much like the terrorists' and "sleepers" who live among normal civilians in different countries for years before they strike, the Vietcong performed as masked bandits who lived and served military personnel by day, and maimed and killed them by night.

- And in Buffalo, NY, in the year 2002, an apparent "sleeper cell" of *American-born* terrorists trained by al Quaida was uncovered. Is it possible that there could be apparent fanatics born, schooled, living with their families and working right here in the U.S., trained to implement untold future acts of terror in and against *their own country*?

How was/is such deception adequate justification to achieve military and political objectives in Kuwait, Bosnia, Somalia, Haiti, Vietnam, and by "global terrorism"? The list goes on, logically or not, and is in apparent contradiction with the prevailing American philosophy that "the means" must be within the bounds of cardinal principles of morality, justice and fair play, no matter how critical the objective? The resulting confusion and the short-and longer-term negative consequences for individual American service members exposed to such devastating war-time experiences, are quite similar to those reactions and their devastating impact upon any number of civilians surviving terrorist acts in America.

The relationship between personal issues and socio-political context. In the Phase II intervention, participants are helped to understand how their *personal* post-trauma emotional reactions are related to the *national and international socio-political context*. For example, the majority of people worldwide, and rightly so, appear to have rejected any reason as justification for the horrific acts that were perpetrated upon the United States. Even so, many people in other countries perceive Americans as minimizing atrocities that occur routinely and internationally, a number of which the United States is accused of having abetted.

Another perspective has been offered by a number of Israelis, who have expressed horror towards and sympathy for the events of 9/11 (Scurfield, 2002a). They have also noted that the magnitude and nature of this trauma will probably give many Americans a much better understanding of the terrorist acts and threats that Israel has been facing on a daily basis for

decades, as well as the extremely difficult decisions that must be made in response. For example, what retaliatory responses (e.g., rocketing or bulldozing the homes of an entire neighborhood of suspected terrorists and sympathizers; "pre-emptive strategies" such as targeted assassinations of suspected terrorists) are morally questionable versus vital, in the seemingly endless and vicious cycle of retribution and salvation of our basic freedoms and American way of life? (Scurfield, 2002a).

Reactions of Americans within this socio-political context are directly linked to our beliefs and convictions regarding related policy issues that face our nation and the international community in combating global terrorism. Do anti-terrorist strategies in the aftermath of 9/11 justify grossly curtailing our cherished freedoms and protections? Can any justification be used to counter massive increases in military expenditures? Must funding for important domestic problems, such as domestic violence, and quality education necessarily be slashed in order to have adequate funds for the fight against global terrorism?

Why do we need to understand their way of life and belief system?

Directly relevant to a second phase of CISD interventions, WTC survivors must be helped to develop awareness of and means to deal with unresolved fears, and the hatred that continue to fuel individual and national actions and reactions. Are hate-filled personal reactions feeding growing racist attitudes and behaviors towards not only individual people of Middle Eastern heritage, but towards the people of entire nations from Palestine to Baghdad to Tehran?

Reactions to civilian devastation. In comparison, the same type of questions clearly arose when speaking with the uniformed men and women of New York, as well as the area local residents' of New York City who witnessed the 9/11 disaster from both near and afar. Others had made an analogy to Pearl Harbor and 9/11, but the usual response appeared clichéd to them. Commonplace responses, usually extremely emotionally-laden, included:

What would make someone do such a terrible thing to us, let alone to innocent civilians?

This is not the same as the attack on Pearl Harbor, they were military personnel, who come to, expect things like this to happen to them.

Why don't we just go over and blow up Afghanistan?

Such thoughts seemed almost universal, driven by our overwhelming sense of loss of safety, both personal and national. Of course, ultimately, terrorists do not engage in traditional warfare. Instead, their tactics are used against any targets of opportunity to inflict terror, disruption, and eventually, to destroy the will and commitment of the people to fight. This means that women, children, the elderly—all innocent civilians as well as military targets, are

fair game (Ayalon, 1993; Scurfield, 2002a). Finally, there is the pejorative labeling that occurs in war, and yes in the face of terrorism, that people engage in to "dehumanize the enemy." How is it that "their" cause and methods are always immoral, inhuman, unjust, whereas "ours" of course are moral, humane and just?

> *"It is instructive to remember that those labeled as faceless cowards or vilified terrorists on one side, are revered as heroic resistance fighters or martyrs, by the other"* (Scurfield, 1992).

Understanding the full scope of losses that have been incurred. During a Phase II CISD, it is important to help participants understand the *scope of the losses* that they have suffered. This is necessary in order to decrease denial and promote conscious coping strategies as part of the on-going recovery process. The loss of the WTC was not only innocent civilian lives; it also was a loss of structure and beauty, and a major arena for entertainment and socialization for thousands of residents and tourists. Families frequently would enjoy the WTC on weekly outings; a place to dine, shop and interact with large numbers of contented people sightseeing and at play. The WTC was an enormous showground for business generating billions of dollars making this a grand arena for a terrorist to destroy. The terrorist mentality recognizes that this American form of socialization is not what "they" desire, but that such destruction would tremendously affect our lives socially and financially.

> *How dare they come and destroy our social gathering place!*
> *I feel so lost not to have the WTC anymore, and so angry*
> *that they could just come and take it away from us.*

Survivors need to grieve. And such grief, as illustrated in the above quote by a WTC survivor, can involve the actual *loss of a physical space*, that gathering place that was the WTC. Of course, there are the additional losses of people, of innocent lives, be they strangers or the deaths of family members, friends, co-workers, buddies, or acquaintances.

> *The only emotion I can recall with clarity (on September 11) is being very frightened. But as I come to terms with things, I feel more of a sense of loss . . . this was my first real contact with death.* (Polk, 2002).

Finally, there are other extremely important losses---the loss of innocence, the loss of security, the loss of ownership, and perhaps a loss of faith in the goodness of humankind.

Normalizing abnormal behaviors distinctive to the terrorist act on the WTC. According to Frankl (1959), an abnormal reaction to an abnormal situation is normal behavior. Understanding this concept *in the context of how one has been living and functioning in the months or years since 9/11* is extremely important (Scurfield, 2000a). And, germane to the rationale for a phase II CISD intervention, the full ramifications of such *longer-term*

reactions that are related to Americans now living in a world fraught with the continuing or indeed increased threat of further acts of terrorism, cannot possibly be adequately attended to in an initial CISD intervention soon after the terrorist act has occurred.

A NYC survivor experienced the act of generating arguments with anyone resembling an individual of Arab descent, especially those wearing turbans, hoping to incite a fight in order to justify taking a swing at that person.

> *I hate what they did, and I would get into a N.Y. cab on purpose just to aggravate a cab driver that looked Arabic or wore a turban. I wanted him to punch me so I could really give it to him.*

This otherwise peaceful, non-racist individual, reacted under what Scurfield (20002a) refers to as "righteous revenge". It was too unmanageable for this individual to grasp the fact that someone could sneak into our country to disrupt the flow of the wonderful social atmosphere provided by the WTC. And so, when the survivor reacted aggressively toward the person who looked to be of Arab descent or wore a turban, he was reacting in a manner to obtain some degree of control over his family's life, possibly by striking out at the most convenient representation of the enemy.

This individual is certainly entitled to these feelings; and yet, purposeful instigation of a violent encounter with "one of them" is hardly an acceptable solution to the problem. Does this suggest resorting to an ill-grounded rage in the face of feeling extremely frustrated and impotent to vindicate themselves against the terrorists and those responsible? This is one stirring example of an inappropriate response (indeed, it would be an act of criminal behavior) that allows hatred, terror and fear to fuel one's reactions towards others or to drive support for certain foreign policies. What other alternatives might one consider?

The exploration of such feelings, reactions and alternatives are critical to an effective phase II CISD debriefing strategy. Survivors can be helped to develop an awareness of such destructive thought patterns, explore the underlying causes behind their feelings of rage and terror, recognize the impact on themselves personally, and what alternative strategies to consider that are not ultimately self-destructive behavior?

Specific Phase II Clinical Intervention Strategies

Cognitive reframing strategies, education, sharing of experiences over the months since 9/11 and reflection in the group setting are powerful tools that help survivors to reframe these issues and put them into perspective.

Cognitive Reframing. Rescue workers cleaned up after the disaster, digging through white ash that was once an enormous body of steel, glass, and office equipment to find remnants of intact office paper, and a preserved lunch of a WTC victim.

> *It was unbelievable to find paper with just singed edges, and the intact lunch of a WTC worker while digging in the rubble and land-fill, yet an entire steel building disintegrated to white ash!*

In this particular case, the rescue worker was consumed with sadness and anger. In this regard, it is possible that the rescued lunch found in the rubble, and the sheet of intact paper that survived the nuclear-like blast, are phenomena that permit the rescue worker to personally process the grief and losses in a symbolic manner. In the course of processing this experience in a CISD group, other plausible reactions and thoughts were posed, and expressed.

> *Could not symbolism of this extraordinary finding suggest that, "No matter what you do to us, we still survived," or that "you can't beat us down, and don't you dare think that you can".*

Maybe that is all that there is to hang onto, and possibly it is important for the individual to believe that something did survive the incineration, and its representation of victory over devastation. Such exploration of alternative thinking and emotional reactions, along with venting of the strong feelings, is a common strategy and outcome of CISD interventions. Indeed, the cognitive reframing process is utilized to guide discussion and reflection about the socio-political issues and personal reactions distinctive to 9/11 and other similar events. Such techniques also typically are utilized in Phase I CISD interventions, e.g., as described by Beck, (1979), Scurfield (1993); and Kubany (1992).

As part of a cognitive reframing process, it is essential to emphasize the dual points that an individual is fully entitled to continue to feel extreme rage, and yet what is the personal cost to the individual to hold onto the rage? Thus, many emergency workers must come to terms with the potential paradox:

> *If I let go of any of my very justified rage, is that not violating the memories and valor of all the innocent people who died,* versus *If I don't let go of some of my preoccupation with rage, I and my loved ones will continue to suffer the consequences of holding onto the rage.*

There is a need to facilitate survivors to reframe this seeming paradox in a way that letting go of the rage does not demean or ignore the memories of those killed. This permits a movement toward greater inner peace and resolution. A brief illustration of how to reframe this issue to enhance increased inner peace and resolution is as follows:

THINK	FEEL	BEHAVE
"Those rag-heads should die."	Bitter, homicidal	Provoke a fight
Reframe the thought		
"They took us by surprise, but they can't control us"	More empowered	Kinder

A second problematic reaction in the aftermath of 9/11 that is amenable to a cognitive reframing strategy involves the continuing painful cognitions and feelings of guilt.

> *I feel guilty because all I did was direct traffic, and watch the equipment and trucks. I should have done more.*
>
> *Other fire and rescue workers ran into the WTC as those inside were running out, but not me. I should have been there with my buddies.*

Normally, people do not purposely run into a crashing building, as each of us possesses a genetically engineered instinct to survive. However, critical incidents such as the events of 9/11 do not fall within the realm of normalcy. Hence, an element of guilt and despair can readily be created, especially for those individuals who felt that they" should have" and "could have" done more. It is not unusual for survivors to ponder such unrealistic, humanistic thoughts after a trauma or disaster. No matter what the circumstances, there is a "wish"—if not a distorted belief-- that one could have controlled the uncontrollable. Such thoughts can become entrenched in the beliefs of a number of post trauma survivors unless timely intervention's can be made to dispel and reframe them in a more pragmatic scenario.

Such issues also can be productively processed through a reframing strategy. For example, rather than remorse and guilt at not getting caught up in the almost frenzied rush of the large number of emergency work responders into the WTC like Pickett's Charge during the Civil War (McKinsey, 2002), the rescue worker is facilitated to recognize that it is a testament to rational thinking and professional training to be appropriately restrained and disciplined in carrying out one's assigned duties:

THINK	FEEL	BEHAVE
Irrational: "I should have run back to save them"	Helpless, hopeless, guilty	Depressed, suicidal
Reframe the thought		
Rational: I exercised what I was trained to do----to be rational, restrained and disciplined during an emergency and carry out my assigned duty.	Calmer, sad yet understanding	Decisive, in-control

Alternative reframe: "It is normal to want to do the impossible. It is the wish that could not be fulfilled. What is to gained to purposefully run into a burning building if there was not a realistic chance to save anyone?	Calmer, more accepting that the situation did not allow for a different outcome	Constructive steps to recognize and deal more realistically with the losses

Thus, it is necessary to address the "should have's", and the "could have's" (Beck, 1979). Discuss that while it is a natural desire or wish to think that "if only" I ran into that building I "could have saved them", that this is cognitive distortion that belies the facts and should never be construed as *the absolute reality* of what would have happened. The American humanistic values conflict with what happened in the tragedy, and survivors need to be aware of how these suppositions can drive the belief system into an unrealistic expectation if not dispelled immediately and appropriately. (Understanding the powerful negative impact of "shoulds" is a key therapeutic strategy in Gestalt Therapy, which offers very helpful treatment techniques (Polster & Polster, 1973).

Attending to the "positive" Ramifications of 9/11: The strategy of cognitive reframing is vitally important to another very powerful dynamic in the aftermath of trauma. If permitted, a number of survivors will *continue to dwell* on the pain and the negative aspects of 9/11; this is not an unusual reaction among trauma survivors (Scurfield, 1993, 1994, 2002a,b).

> *Many people will never understand what I deal with inside. Perhaps, it's easier to expect me to move on a year after the attacks because my wounds reside mostly inside of me. Even those close to me, though they try, struggle to relate to my experience.* (Carlisle, 2002).

On the other hand, the impact of 9/11 on a number of people clearly has not been *only* a traumatic or negative one. There have been numerous accounts of a range of more positive outcomes that also have been experienced in the aftermath of 9/11.

> *As time has passed since that horrific day we have all seen the incredible resilience of the American human spirit . . . Tragedy makes us stronger and pulls us closer. May we all learn from Sept. 11 just how fragile life really is----and how blessed we are to have our families. Let's also keep in mind how lucky we all are to live in a country that provides freedom and opportunity.* (Boyle, 2002).

Thus, a critical element of a Phase II CISD is to insure that at least some time is spent helping survivors to be aware of and appreciate any positive aspects related to 9/11. This is not

to deny the negatives; on the contrary, it is to emphasize that along with the negativity, such positives as the courage and strength of the human spirit can and do prevail through the most horrific of experiences (Scurfield, 1993, 1994; Schiraldi, 2000)---including 9/11. Life can indeed take on new, or renewed, meaning.

> *Personally, the shock waves of Sept. 11 have created a new focus on family and community, and an awareness that America is still the best place in the world to live. I don't take anything for granted anymore. Friends are here today and gone tomorrow. I don't take the right to work and serve the community for granted anymore. Americans prayed openly, and there was a real feeling that we were truly one nation under God, indivisible. (Scallan, 2002)*

Other Areas of Focus in Phase II CISD Interventions. Depending on time constraints and specific presenting concerns of the participants, one or more of several additional following content areas may be very appropriate and needed as part of a new or "booster" emphasis to accomplish in a phase II CISD intervention. It is recognized that the following may have been touched upon in an initial CISD intervention. However, there is no way of knowing how much of the following information, even if had been provided, *was actually absorbed and integrated* at the time or later into thoughts, feelings and actions by survivors. Thus, a "refresher" mini-educational course may be quite appropriate. [An alternative or supplementary strategy is to provide the following in handouts.]

Stress reduction and coping: Since a considerable amount of time may have passed between the traumatic event and a Phase II CISD intervention, it is particularly important to spend at least some time reviewing with participants how they may have used successful coping techniques to deal at least in part with the aftermath of 9/11, and what additional coping and stress reduction techniques may be suggested. Stress reduction and relaxation techniques (Benson, 1975) are a specific kind of coping skill that can help survivors to understand how to relax, and put into perspective what is happening to them emotionally and physiologically (e.g., exercise, meditation, visualization techniques, relaxation techniques, etc.) in order to decatastrophize those powerful negative thoughts (Shiraldi, 2000).

Stress and the body: It is important to understand or be reminded of the psychological impact of stress and the brain chemistry, in addition to the relationship between physiological and emotional responses. For example, how one can decrease the surge of adrenalin through cognitive reframing to prevent the subsequent manifestation of severe anxiety, depression, suicidal impulses, PTSD, and a related predisposition to substance abuse. Education regarding the brain chemistry is essential, to know and understand how chemical changes during exposure to stress and subsequent exposure to stressors are believed to result in chronic and magnified noradrenergic activity. This is readily manifested through responses indicating fear and aggressive behavior. Once the trauma ends, opioid levels decrease and adrenergic hyperactivity begins. This in turn causes symptoms of withdrawal, startle responses, anxiety, hyper-alertness, and sleep disturbances. (van der Kolk, Greenberg, Boyd and Krystal, 1985).

Medication: If necessary, medication may be a necessary or helpful adjunct to CISD or other psychological intervention. Appropriate medications can help to decrease the adrenalin surges, sleepless nights, and hyperactive startle responses (Viola, Ditzler, Batzer, Adams, Lettich, Harazin & Berigan, 1996). Someone who may have been resistant to medications for severe initial post-9/11 reactions may be more amenable in the face of a prolonged reaction.

Gestalt perspectives: In addition to being utilized as part of a cognitive reframing strategy, Gestalt Therapy experiential or "in-action" techniques offer helpful interventions for persons who may only be able to get a limited benefit out of "talking only" therapy. For instance, when an individual is distraught and obsessed with angry feelings, in addition to *talking about* the feelings, the person can be offered an experiential strategy, or he/she can be facilitated to design his/her own experiential strategy that is personally meaningful, e.g., the problematic thoughts can be written on paper and processed in a ceremonial manner such as: inserting the paper in a box, burning the box or throwing it into the ocean (Perls, Hefferline, and Goodman, 1951; Polster & Polster, 1973; Obenchain & Silver, 1991). Also, for a "shared" trauma such as 9/11, the positive therapeutic benefits of carrying out such an experiential or ceremonial action can be increased many-fold by occurring in the presence and with the support of peers who also are struggling with their post-9/11 reactions.

The Evaluation Challenge: Assessing the Outcome of Initial or Repeated CISD Inteventions

There is an enormous challenge in terms of overcoming problems related to being able to design and conduct a valid evaluation of typical one-time CISD-type interventions. The authors readily admit that our involvement in the POPPA debriefings and in meaningful human-to-human encounters with many of the uniformed emergency responders to the WTC tragedy makes it difficult for us to be entirely objective about how helpful these interventions have been. Certainly, our *subjective* observations and experiences tell us that such interventions are a worthwhile and important service to provide, and self-reports by a number of the survivors offer a degree of corroboration of our clinical observations and impressions.

Earlier, the authors briefly referenced the on-going controversy over the efficacy of CISD interventions. There is an alternative position that merits consideration. The authors suggest that it may well be that the *wrong evaluation question* has been asked and assessed when the judgment about the outcome efficacy of CISD interventions seems to hinge on the issue of *whether participants' PTSD has been prevented, improved or eliminated.* Preventing or reducing PTSD may be an unfair, if not indeed a very unrealistic, expectation and demand of CISD interventions. Consider the evidence that PTSD symptoms are extremely resilient, *even in the face of intensive PTSD therapeutic interventions* (e.g., Fontana & Rosehneck, 1996a, 1996b; Fontana & Rosenheck, 1997). Also, the enduring nature of PTSD has been well documented in studies of Vietnam veterans (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar & Weiss,1990). And, there is evidence of a genetic predisposition to the development of PTSD (True, Rice, Eisen, Heath, Goldberg, Lyons & Nowak, 1993; Xiang, Chantarujikapong, Scherrer, Eisen, Lyons, Goldberg et al, 2000; Segman, Cooper-Kazaz, Macciardi, Golster, Halfon &

Dobrokorski, 2002). Finally, in response to the 1993 World Trade Center bombing (Koplewicz, Vogel, Solanto, Morrissey, Alonso, Abikoff, Gallagher & Novick, 2002), there was a persistence between three month and nine-month follow-up evaluations of the levels of PTSD symptoms in children who were directly exposed to the WTC bombing.

If there is a persistence of PTSD symptoms following trauma exposure as described in such research findings, how realistic or fair is it to base an evaluation of the efficacy of typically *one-session* CISD interventions on whether CISD "prevents" or "cures" PTSD? Furthermore, there is PTSD research (Hyer, Scurfield, Boyd, Smith & Burke, 1996) that suggests that *qualitative* research methods may offer a more valid outcome measure of the impact of interventions on PTSD than standardized psychometric instruments. Along this same line, Scurfield and Wilson (in press, 2003) present a comprehensive critique of the Department of Veterans Affairs multi-site studies of the outcome of VA specialized PTSD treatment programs that documented the "failure" of intensive inpatient PTSD programs and specialized outpatient PTSD programs. Scurfield & Wilson contend that there are numerous outcome indicators *other than* the reduction or elimination of cardinal *DSM-IV-TR* PTSD symptoms that are important to consider in assessing the impact of PTSD treatment. These indicators include associated, as distinct from core, features of PTSD (such as self-destructive behaviors, self-worth and personal identity, impaired affect modulation, guilt, shame, isolation and hopelessness), quality of life, patient satisfaction, and a more benign attitudinal and emotional response to trauma memories and to PTSD symptoms.

Related to the above literature, a colleague recently voiced what the authors consider to be an alternative and more valid outcome question to ask of CISD interventions: *what therapeutic value do CISD interventions serve, if any?* (Holland, 2003). If researchers ask and investigate this broader question, a more valid understanding of the benefits and limits of CISD interventions may be forthcoming. The authors' subjective impressions are that CISD interventions can have an impressive impact in such domains as the ability to normalize reactions to extraordinary events, promote bonding and peer support, offer a helpful catharsis of emotional expression, increase cognitive reasoning and the identification of helpful coping strategies---*while not necessarily reducing or eliminating* PTSD or core PTSD symptoms as defined by the *DSM-IV-TR*. Such a possibility requires out-of-the-box thinking about what are the valid research questions to even ask, let alone creative evaluation strategies concerning the possible impact of CISD interventions. The evaluation issues are further complicated when considering possible Phase II CISD interventions. For example, there are such issues as the varying length of time between a first and second intervention, lack of systematic random assignment to those receiving (or not) a second intervention, and intervening variables between the initial and subsequent CISD intervention that may be important explanatory factors contributing to a positive change or lack of.

The authors welcome a dialogue regarding such outcome evaluation issues. It is our hope that mental health research and evaluation strategies can be undertaken to facilitate empirical outcome data that might corroborate and/or challenge our subjective impressions regarding the positive therapeutic impact of the provision of CISD interventions *and* of the efficacy of providing Phase II CISD interventions.

Conclusions

This paper has described both how a horrific, destructive, unexpected event such as the 9/11 attack upon America can impact the lives of survivors and all levels of responders, and clinical experiences in conducting an initial phase of CISD interventions with some of the survivors. This deplorable event caught Americans unaware and unprepared for a disaster of this enormity. The New York Police Department and POPPA rallied with a group of courageous men and women to take the lead in a major debriefing process lasting up to eight months in response to the needs of their brothers and sisters in desperate times.

This entire process has set a precedent, and because of the myriad "lessons learned", we must look at how to even better prepare to address the potential negative consequences of other terrorist attacks of an exceptionally large or smaller scale. A model has been proposed and described to supplement the already helpful initial CISD procedure with a Phase II process to address profound issues that were simply impossible to address during initial, very time-limited, one-shot CISD interventions that occurred soon after 9/11. Such issues include aspects distinctive to the trauma of 9/11 such as the confounding of personal reactions with national and international socio-political events and dynamics, and positive ramifications related to the aftermath of 9/11. Also, hopefully subsequent experiences by various clinicians will help to design and conduct a Phase II CISD intervention or follow-up process, similar to or modified from the model described in this writing. Furthermore, there has been a brief discussion of the challenge of valid evaluation of typical CISD interventions, let alone the further complications in attempting to gather objective and valid outcome data of a Phase II or repeated CISD intervention strategy. The authors welcome and invite suggestions and recommendations that could facilitate a valid outcome evaluation of the possible therapeutic impact of two (or repeated) CISD-type interventions.

In closing, to have suffered from the initial tragedy of 9/11 is bad enough. We must be vigilant and creative in insuring that terrorism does not dictate a lasting negative impact on it's intended victims----America and Americans. A Phase II CISD intervention process such as the one described, along with follow-up, may help to both promote healing from the traumatic aspects and enhance appreciation of more positive aspects that were not possible to address in early-intervention CISD's. For some survivors, such an appreciation is possible through one's own personal efforts and the support of significant others. For other survivors, assistance through CISDS debriefings and/or counseling with mental health professionals may be required. Is it not our duty to help to facilitate as many people as possible who were impacted in the aftermath of 9/11 to be able to affirm an enrichment of their quality-of-life---and to be as prepared as we can for offering the most effective interventions in the aftermath of any future terrorist attacks?

I feel more relaxed. It's an appreciation of life. I don't stress about stuff like I used to. I feel more family focus . . . I feel a much greater respect for police and firemen. I look at them differently. Every one of them puts his or her life on the line every day. I'm thankful for being able to choose from an array of food. What a gift it is to be able to have our abundance of choices. I have a new feeling of thankfulness for the country we live in. (Firmin, 2002).

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