This article provides a case study of the development of a participatory psychoeducational workshop that was rapidly developed and disseminated to an affected community in response to the attack on the World Trade Center (WTC). The workshop provided conceptually, empirically, and experientially grounded training to community and educational personnel on responses to disaster and trauma, resilience, tolerance, and compassion fatigue. [Brief Treatment and Crisis Intervention 2:75–83 (2002)]

KEY WORDS: crisis, disaster, psychoeducation, trauma.

The events in the United States since September 11, 2001, have created a climate of apprehension and fear that is challenging the emotional resources of the nation at large. It is also taxing the collective wisdom of mental health practitioners and other community and educational professionals who have been trying to put these events into a context that facilitates healthy adaptation and coping in an atmosphere that sometimes changes hourly with the surfacing of reports and rumors about new terrorist threats.

Because of its physical proximity to the World Trade Center and the large number of New Jersey residents who work in New York City, New Jersey was significantly affected on a primary level by the terrorist acts across the Hudson River. The impact of the trauma within New Jersey was significant, with large numbers of persons missing in the WTC living in the bedroom communities of northern and central New Jersey tethered to the commuter train lines into New York City. Communities across the Hudson River had an ongoing bird’s eye view of the unfolding catastrophes. First-line responders included police, fire departments, and emergency
medical technicians, as well as scores of mental health workers who were dispatched to intervention sites both within New Jersey as well as in New York City. From the perspective of disaster theory, the impact for many was on a personal, primary level.

The secondary level of trauma impact was also significant. Proximity to the epicenter of a disaster can understandably increase awareness of its short- and long-term consequences. Smoke from the fires that burned in the aftermath of the WTC attack drifted over New Jersey for days, while the New York skyline, New Jersey’s uniquely personal view of the city across the Hudson, was dramatically altered, first with billowing smoke that lasted for weeks, and then with a gaping emptiness. Access to the city was changed as traditional tunnel crossings were closed or entry was severely limited. There was no way to pretend New Jersey’s relationship to New York City would ever be the same.

The unprecedented scope and nature of the event presented a challenge for interventionists because all of them were personally affected by the disaster. Thus, they needed to process and come to at least some initial terms with the disaster. Moreover, this disaster was unique, at least to Americans, because it was not a discrete event, but included the concern and promise of subsequent attacks. Finally, the growing phenomenon of the convergence of self-proclaimed and often ill-informed trauma and disaster “experts” (Gist, Lubin, & Redburn, 1999) intensified the need for a careful consideration of what might or might not be useful and appropriate for such an unprecedented event.

It was clear, then, that those whose roles required that they provide assistance to adults and children in the wake of the disaster needed an opportunity to discuss their personal and professional responses, to affirm or obtain a framework with which to inform their interventions, and to pool their efforts to sift through the rumors and misinformation. Note, that we are not referring here to the need for first responders to “debrief,” but to a more informal opportunity to discuss among themselves what their personal and professional responses have been. This distinction will become clearer when we discuss elements of the workshop for providers.

Most providers were working with families and children, and the question that arose again and again was what could be done to help the children who have been exposed to and affected by these disastrous events. While it is understandable and appropriate to be concerned about the impact of any disaster on children, it is important not to overlook the critical first step in the process of helping children recover. Unless the adults who are responding to children are assisted in understanding and processing their own reactions, they will be ineffective in providing help to anyone else. The unprecedented nature of the events of September 11 left many adults in shock; even adults with extraordinary ranges of coping skills had no context in which to organize their responses to this disaster. In addition, the perception that terrorism now inhabited American soil created a new and frightening reality that for many was beyond comprehension. Caught between shock and fear, many adults seemed psychologically paralyzed.

The Response Model

The remainder of this article describes a workshop developed for community and school professionals who were responding to the needs precipitated by the WTC and Washington attacks. The purpose of the workshop was to provide a framework and resources for providers to assist them in promoting effective responses among their individual and family clients to the WTC disaster and the new reality of continuing terrorist-induced community trauma. While these events seemed unprecedented, we subscribe to the tenet, often ignored in our field,
To be ignorant of what occurred before you were born is to remain always a child” (Cicero, *Orator*, section 120). Thus we began with classic crisis intervention concepts to frame our intervention. Crisis intervention traces its origins to World War II. Col. Albert Glass (1958) noted that whether soldiers exhibited crisis responses to combat was related to the circumstances of the combat situation rather than preexisting personality factors. While these circumstances included the intensity and duration of combat, the degree of support from buddies, group cohesion, and leadership were even more important. He also noted that defensive (coping) patterns adapted by individuals in the face of stress are molded by the social pressures of the group. Over fifty years later, Kaniasty and Norris (1999) stated that in disasters the reality of individual victimization cannot be understood without consideration of the collective reality at several levels: environment, social, psychological, political, and cultural. This ecological view of crisis intervention was emphasized throughout the workshop.

During WWII, it was also discovered that treatment that was provided in field hospitals close to the front by nonprofessionals who took an active approach and conveyed that the soldier was expected to return to his unit as quickly as possible was more effective than removing the soldier from his milieu, and hospitalizing and diagnosing him. In the latter case, soldiers assumed the patient role with the concomitant symptom syndromes. Today, effective crisis intervention takes place through outreach to the affected sites by those familiar with and to the local environments. Kaniasty and Norris (1999) identified the increased credibility and rapport derived from being a part of the community served and sharing to some degree the impact of the disaster. However, they noted the downside that the support providers are victims themselves and consequently also need support. This has clearly been the case in the New York–New Jersey metropolitan area, and was a major impetus for the workshop. The workshop emphasized the importance of avoiding pathological labels for the majority of affected individuals and the necessity for providers to monitor their own reactions and maintain their own support networks.

The workshop also reflected the core activities of crisis intervention that are the provision of both support (e.g., Eckenrode, 1991) and an intellectually based context (e.g., Taplin, 1971) around which individuals can organize and understand their responses. As such, the workshop models this process by providing support and structure to participants and practical resources that enable them to do the same for their clients. Information provided during the course of the day was structured to facilitate understanding of the normal range of response of adults to disaster before issues related to children were considered. Content areas also reflected the premise that the disaster that occurred on September 11 marked the beginning of a new personal and collective consciousness that must incorporate recognition of terrorism and its sequelae in order to be adaptive.

While the tenets of crisis intervention provide helpful guidance for immediate response to these events, one must be familiar with continuing developments in the field. For example, an early presumption of crisis intervention was that the goal was to return those affected to pre-crisis levels of functioning. Under the current circumstances, this appears inadequate and naïve. However, more recently Caplan (1989) noted that life predicaments appear to be turning points of lasting significance. Kfir (1989), drawing on experiences in Israel, stated that crisis means disengaging the automatic pilot—our usual ways of coping—in order to open up the possibility of new solutions, rather than rushing to mend and restore the old automatic pilot.

Thus, it is important to consider classic and current crisis intervention strategies as the
foundation upon which an intervention is based and to include as well the recent practical applications of both disaster and trauma theory as intrinsic intervention components. Framed with the supportive and structuring components of crisis intervention, this strategic combination provides the context for development of a perspective for living in the United States that includes incorporation of the reality of continuing terrorist threats. In addition to basic crisis intervention, several other frameworks informed the content and structure of the workshop.

First, the workshop drew upon another response program, Managing Sudden Traumatic Loss in the Schools (Underwood & Dunne-Maxim, 1997). This program employs a systemic model that has been used in hundreds of schools across the country to contain and manage the impact of suicides, homicides, accidents, and other types of traumatic deaths. It utilizes the tenets of crisis intervention, suicide prevention, and grief theory to provide a paradigm that emphasizes the provision of support, control, and structure in response to traumatic loss events. This model also recognizes the importance of considering trauma in a community context, and the involvement of the larger community in traumatic death recovery is an essential component of the intervention design. Not only is responsibility for recovery shared and resources increased, but a community consciousness is created that can buffer the impact of the stigma with which traumatic loss events are frequently perceived.

Because trauma potential in the aftermath of a disaster is related to an individual’s perception of certain characteristics of the impact, the information about these variables was also provided in an interactive format to allow participants to process and share their own perceptions of the disaster events. Experience with a variety of disasters has revealed that these characteristics include such things as duration of the event, perception of its unexpectedness, proportion of the community suffering losses, sociocultural changes during recovery, and the level of terror and horror at the witnessed events. The symbolism of the event is also considered, with intentionally perpetrated events having a higher potential for trauma (Gist & Lubin, 1999; Weaver, 1995). Structuring impact characteristics in this way provided a specific framework for appraising personal reactions and helped participants organize thoughts and feelings that for many had seemed as chaotic as the events themselves.

Community context is also highlighted by disaster theory in its definition of the intrinsic qualities of disaster events (Caplan, 1989; Gist et al., 1999). This ecological view recognizes that a disaster is more than an assortment of individual experiences and is, by definition, a collective experience that not only overwhelms the community’s resources but also requires the community’s resources for recovery. This acknowledgment of community impact is a critical element in personal adaptation to disaster, answering the feelings of isolation and separation that often paralyze survivors. By sharing experiences and resources, survivors at both a primary and secondary level are joined not just in pain but also in coping. Throughout the structure of the day, the workshop content called the attention of participants to the importance of community context, embracing that theme through the use of an Irish proverb, “It is in the shelter of each other than we live.”

Internet access has contributed to the expansion of community to a global scale. For example, reports to a listserv for crisis services indicated that crisis centers around the country were prepared for an onslaught of calls after the attacks, but found the lines unusually quiet. Messages from listserv members from Israel, Ireland, and Turkey all said that this was to be expected and to be prepared for an increase in calls as the initial shock and mutual support wears off. This appears to be happening as of 5 weeks
after September 11. The exception to this pattern was crisis lines in Northern New Jersey that experienced a significant increase in calls that has not abated, as callers first sought information and then began to deal with grief and loss. This global input not only provided valuable information, but also helped to reduce the isolation felt by local caregivers affected at primary and secondary levels. Consequently, the experience of those who are dealing with war and disaster also informed the workshop design.

While disaster theory presented a psychosocial context for understanding and responding to the events of September 11, an existential or spiritual framework also seemed essential for helping participants reorganize a world-view that incorporated continuing terrorist threats. Drawing upon the work of Janoff-Bulman (1989) and Kfir (1989), the workshop emphasized that personal perceptions or assumptions about life had been shattered by this trauma. These assumptions included such things as beliefs in the world’s inherent goodness and justice and the kindness and trustworthiness of most people in it. Kfir (1989) also noted a system of basic personal beliefs, such as the belief that, “Life is meaningful and I can survive only if I can control my life and the events of life that surround me.” According to these authors, these assumptions can be damaged whenever individuals confront traumatic situations.

The challenge of healthy coping is to subsequently reconstitute these assumptions, incorporating the new and painful reality that they may, in fact, sometimes be violated. Children’s assumptions, according to Janoff-Bulman (1989), are in the process of development, and are strongly impacted by the messages they receive from the adults in their lives. While they may not escape from trauma unscathed, children are also flexible and resilient. Directly addressing these beliefs and their violations with children at developmentally appropriate levels can facilitate their readaptation of them in a new, more mature way. Using the workshop’s strategy of employing a broad range of examples to illustrate didactic material, this particular point was underscored with a line from The Diary of Anne Frank: “In spite of everything, I still believe that people are really good at heart.”

Another context in formulating the workshop’s comprehensive approach to this trauma is mental health concepts. In the aftermath of September 11, mental health services were offered without charge by a multitude of agencies and organizations in the region. While mental health services were necessary, their perceived emphasis on “critical incident stress debriefing” and premature diagnosis of “posttraumatic stress disorder” clouded the fact that the majority of the population exposed to these events will not need formal mental health interventions to process their reactions. Thus, as with others who overestimated the need for mental health services in disasters (Gist et al., 1999), the lessons of WWII had to be relearned.

Consequently, the concept of resiliency was one of the most critical elements in workshop content (Haggerty, Sherrod, Garmezy, & Rutter, 1996; Wolin & Wolin, 1993). Resiliency was intrinsic to empowerment of participants for the development of adaptive coping to these traumatic events. For example, an aspect of resiliency is the ability to perform the basic tasks of living in the face of overwhelming tragedy. Understanding and recognizing the resiliency of survivors may short-circuit inappropriately applied diagnostic formulations of pathology related to what appear to be underreactions to the seriousness of the traumatic events.

Finally, the workshop emphasized that what most people will need are continuing opportunities to talk about their reactions with respectful and supportive others until they can organize the events in a way that makes some degree of sense. This technique of “obsessive review” (Weiss, 1975) is borrowed from grief theory and reflects the need for continued processing of sudden loss in order to eventually
come to terms with its occurrence. For most people affected by this trauma at a secondary level, this technique will allow them to organize both the events and their reactions in a manner that helps in regaining emotional control and re- building the assumptions about the world that were shattered by these events. Over time, the need to obsessively review diminishes as reconstituted control in a changed reality progresses.

**Workshop Overview**

Table 1 provides an outline of the workshop, including topics, rationale, presentation method, and sample handouts. Handouts from many sources such as professional books and journals, literature, websites, and newspapers were provided and only samples could be included here. Primarily didactic in nature, the workshop also included opportunities for discussion and validation. The workshop began with videotaped segment from a public television news program (Moyers, 2001) to stimulate discussion about personal responses to the trauma. This segment was carefully chosen because it did not replay any graphic images of the disaster, out of concern that some of the participants might be retraumatized by yet another viewing of the specific events. Instead, the segment featured citizens from the New York–New Jersey metropolitan area describing their reactions to the WTC attacks. As previously noted, this initial opportunity to discuss reactions to the events and current intervention efforts was not intended as a formal debriefing. Rather, providing participants with an opportunity to discuss their previous responses and current feelings about and attitudes toward the training content is a common strategy used by trainers to engage participants and to connect the content to their current experience (Knowles, 1978). In this case, it also follows the basic crisis tenet of starting where the client is, and all of the participants were affected by the events. Finally, this initial sharing conformed to an emergent norm in the metropolitan area for the period immediately after the attacks on the WTC: Every initial contact with colleagues began by asking about how they were impacted by the attacks, before proceeding to the business at hand.

Common normal reactions to disaster from a mental health perspective were also reviewed in the workshop. While a plethora of Internet sites outlined common physical reactions to disaster and trauma, there appeared to be less accessibility to information about the common psychological reactions most people seemed to be experiencing. While participants, for example, were familiar with the symptoms of separation anxiety often evidenced by traumatized children, they had not applied this same concept to their own needs to stay close to home, surrounded by family and friends. The fact that the need for community connection is also a healthy psychological trauma response was reviewed to help participants redefine what may have been perceived as simple altruism as an adaptive coping response. Emphasis was also placed on helping participants identify the many kinds of losses attendant to the disaster and the need to evaluate those on both concrete and emotional plains. For most Americans, the loss of a way of life must be acknowledged and mourned before a new reality can replace it.

The video (Underwood, Shepherd-Levin, & Cernak, 2000) presented youth’s accounts of their response to a major flood and the impact of community interventions on them. This was followed by discussion and a presentation on children’s grief, and how disaster, and particularly intentional disaster, complicates grief.

Participants had encountered many instances of individual and community resilience and mutual support in the face of the disaster, and their experiences formed a context for a review of resilience in children and families.
### Table 1. Workshop for Educators and Mental Health Providers

<table>
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<tr>
<th>Topic</th>
<th>Rationale</th>
<th>Method</th>
<th>Sample handouts</th>
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<tbody>
<tr>
<td>Responses to disaster</td>
<td>Participants need to review their personal and professional responses to the disaster to provide a context and meaning for material to be presented</td>
<td>Video and discussion</td>
<td>Wakin, D. J. (2001, September 20). Unthinkable and now, unspeakable: Attacks transform perceptions and words. The New York Times, p. 43.</td>
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<tr>
<td>Compassion fatigue</td>
<td>Disaster threatens to overwhelm empathic resources leads to need for strategies to maintain emotional balance.</td>
<td>Group discussion</td>
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There were some instances of ethnic intolerance in the wake of the attacks, and participants were provided an opportunity to review resources and strategies for addressing this, particularly in school settings with which many of them consulted.

Finally, participants were reminded that they must retain their own resources and supports in the face of the ongoing demands on their time and compassion. Many formed mutual support networks at the workshops.

Conclusion

This article provides a case study of the development of a participatory psychoeducational workshop that can itself be considered a crisis intervention. This workshop has been provided to several hundred educators and mental health practitioners in New Jersey. Feedback from these workshops indicates that participants valued the opportunity to process their reactions in a structured format that assisted them to organize their responses in the context of individual and community coping skills. The workshop organizers had to rapidly pull together materials that were conceptually and empirically grounded to counteract misinformation, and also draw on media reports of the community experience and the experiences of the participants themselves in order to make the workshop relevant to issues with which they must continue to deal. In order to rapidly disseminate the workshop, the organizers drew upon their network of community contacts that had been developed by their university-based technical assistance center that provides training to community and educational personnel in a variety of crisis-oriented topics.

The workshop was also adapted for presentation in schools in communities that were most affected by loss of lives. Additional workshops are planned that will address practical techniques for managing the effects of traumatic loss in youth, the challenges of parenting by surviving parents, and the broader sociocultural context of grief and trauma management. Future workshops will also address the critical need to expand resources for dealing with trauma to include literature and art, spirituality, and mutual support groups. In this way, the emerging needs of the statewide community will continue to be addressed by enhancing the resources of community gatekeepers.

References


