An Examination of the American Response to Terrorism: Handling the Aftermath Through Crisis Intervention

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The United States has never seen terrorist attacks such as those experienced on September 11, 2001. Following the attacks, many individuals have struggled with how to best address the vulnerabilities of American society relating to terrorist activity. This article identifies several issues that can affect the previously open nature of the American lifestyle with impending threats of biological warfare. This turbulent environmental context has caused the American people to experience a level of stress never before experienced. The purpose of this article is to present a brief overview of America’s policy on terrorism stressing the application of Roberts’ seven-stage model of crisis intervention as one means to address the growing fears of the American public. All helping professionals, whether or not they’re working directly with a crisis survivor, need to be aware of basic crisis intervention techniques. Application of this model is stressed as one way to provide education in this area while highlighting how to best help individuals cope when faced with the continual threat of a new and different type of war. Recommendations for therapeutic content are made within the current time-limited practice setting. [Brief Treatment and Crisis Intervention 2:287–300 (2002)]

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The United States, along with the rest of the world, was shocked and stunned as the terrorist attacks of September 11, 2001, unfolded. Following the attacks, debates relating to terrorist activity within the United States and the vulnerabilities inherent within American society began to emerge. The issues of extensive borders and the relative ease in which immigrants can disappear into American society, as well as the global and open nature of lifestyles Americans have come to depend upon, leave the society susceptible to terrorist threats and attacks. Furthermore, the threat of biological warfare and fears of a new type of war abound. This has caused the majority of American people to experience a newfound level of...
stress. The purpose of this article is to present a brief overview of America’s policy on terrorism, and to reveal the need for a proactive joining of law enforcement, government agencies, and professional practitioners. These groups can collectively assess potential threats within the United States and address the growing fears of the American people in regard to safety and security for the American public.

Terrorism and the United States

Terrorism is defined by the Department of Defense as “the calculated use of violence or the threat of violence to inoculate fear; intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious or ideological” (Terrorism Research Center, 2000). Terrorism is a crime that targets innocent and unsuspecting victims, and its purpose is to heighten public anxiety. Also, while acts of terrorism may seem random, they are actually planned by the perpetrators whose main objective is to publicize their attacks. The growing threat of terrorism and terrorist activity is expanding across the United States, and success in combating it will require agencies to implement proactive approaches and strategies (Terrorism Research Center, 2000). “It is time to recognize certain events that are currently occurring in society as potential forewarning. Disregarding them may result in tragic consequences. History clearly shows that those law enforcement agencies caught behind the operational curve of [terrorist] campaigns have a harder time controlling them and reducing their societal disruption than those that are properly prepared” (McVey, 1997, p. 7).

Terrorism Trends

It is the current trends in terrorism and terrorist activity that makes the need for a proactive approach critical. These trends include the following: (a) terrorism is becoming the war strategy of the future; (b) terrorists are becoming more sophisticated and proficient at using technology; (c) the targets of terrorist attacks will advance from buildings and airplanes to economic systems and countries; (d) traditional weapons will become obsolete against technically advanced terrorists; and (e) the United States will continue to be a target of terrorism (Badolata, 2001; Bowman, 1994).

Since the 1980s, the United States has had a policy relating to counterterrorism; however, it is largely reactive in nature and lacks preemptive capabilities. This four-pillar policy states: (a) the United States makes no concessions to terrorists and strikes no deals; (b) the United States uses a “full-court press” to isolate terrorists, and to apply pressure on state-terrorism sponsors in order to force them to change their behavior; (c) rules of law are followed to bring terrorists to justice; and (d) the United States seeks international support to increase counterterrorism capabilities (Badolata, 2001).

United States Vulnerabilities

Examining the vulnerabilities inherent within the United States further supports the need for a preemptive approach to combating terrorists and terrorism. First, the United States has an extensive amount of borders that are extremely easy to penetrate. Millions of legal and illegal immigrants enter the country each year. Second, the security measures at airports and other ports of entry are poor, and resources are stretched thin. In most cases personnel that are undertrained and ill equipped are hired to secure ports of entry. Third, the structure of law enforcement in the United States can also be seen as a vulnerability because federal, state, and local agencies often lack communication between them and, in cases where jurisdictions
and charters overlap, friction between the agen-
cies often occurs. Finally, the infrastructure of
the United States has been centralized, allowing
for large concentrations of people to inhabit rel-
atively small areas. These large population areas
capture the attention of terrorists because they
allow for a larger casualty rate and a more pub-
lic arena for attacks (Terrorism Research Center,
2000).

Since the September 11 terrorist attacks, gov-
ernment and law enforcement agencies have be-
gun to implement strategies to counter these vul-
nerabilities. However, the “openness” of Amer-
ican borders, which is the most critical area in
need of change, is the most difficult vulnera-
bility to effectively control. The current influx
of immigrants into the United States highlights
the necessity of an effective system that can
scan and monitor those individuals entering the
United States.

Problems Contributing to Increased Terrorism

In the United States in 1991, there were 455
million entries made to the United States by
immigrants and international travelers via air,
land, and sea. By 1993, that number had in-
creased to 483 million entries; in 1995 alone,
at the ports of entry to the United States the
4,000 immigration inspectors intercepted al-
most 800,000 persons who were ineligible
for admission into the United States. Further-
more, there is no estimate available as to the
number of those who were able to escape
detection (Badolata, 2001; Gibb, 2001; Hays,
1996; McDonald, 1997). This massive amount
of entries is problematic in that there is no
effective national system that screens those in-
dividuals coming into the United States. The
infrastructure necessary to efficiently process
this increasing movement has not kept pace
with its growth resulting in an easing of the
barriers that formally kept out ineligible trav-
elers such as criminals, terrorists, and economic
migrants.

Bioterrorism: Threats of Anthrax and Smallpox

Individuals, groups, or governments define bio-
terrorism as the expressed purpose of causing
harm for ideological, political, or financial gain
(Texas Department of Health, 2001). Further,
biological weapons are defined as referring to
as any infectious agent such as a bacteria or vi-
rus, which is used intentionally to inflict harm
(Texas Department of Health, 2001). Since the
September 11 attacks the threat and fear of bio-
terrorism has escalated within the United States.
The recent cases of anthrax infections have
exposed America’s vulnerabilities to biological
agents, and has highlighted the need for greater
security measures to protect against bioterror-
ism attacks.

Bioterrorism Possibilities

According to the Center for Disease Control and
Prevention (CDC), biological agents can create
a risk to national security because they are eas-
illy disseminated. Furthermore, bioterrorism can
have high mortality and great impact on public
health systems, causing panic and social disrup-
tion. This high cost of bioterrorism could lead
to special action and funding to increase pub-
lic preparedness (Scardaville & Spencer, 2001).
Bioterrorism mirrors conventional terrorism be-
cause it is designed to affect a large number
of people, can be implemented with little or
no warning, and instills panic and fear in the
population. However, there are several other as-
pects of bioterrorism that must also be ex-
amined. First, the vast number of methods that
can be used to spread biological agents into
an environment is a concern. Airborne dissem-
ination, pharmaceutical contamination, food or drink contamination, injection or direct contact, and water contamination are all methods that can be used by terrorists attempting to unleash biological agents (Scardaville & Spencer, 2001). Other considerations that must be taken into account include the vast number of biological agents that could be used in a bioterrorism attack, the ability of terrorists to acquire such biological agents, and the massive casualties that could result if a bioterrorism attack occurs.

**Anthrax and Smallpox**

The biological agent that has gained the primary attention since the September 11 attacks is anthrax. Anthrax, according to CDC, is an infectious disease that is caused by the spore-forming bacterium *Bacillus anthracis* (CDC, 2001a). Although it is not contagious, humans can contract the disease through inhalation and breaks in the skin. If contracted through inhalation, the incubation period is generally 2 to 5 days, and the symptoms mirror those of the flu—fever, muscle aches, nausea, and coughing. More serious symptoms include difficulty breathing, high fever, and shock. Inhalation anthrax is almost always fatal once symptoms appear. If contracted through the skin, the incubation period is generally 1 to 2 days. Symptoms of skin exposure to anthrax begin as a small, itchy bump followed by a rash. Left untreated, the lesions fill with fluid and eventually turn black as the tissue begins to die. About 20% of untreated cases of infection through the skin result in death (Gibb, 2001, p. 44). Anthrax, although potentially fatal, can be treated effectively through antibiotics if initiated early (CDC, 2001a).

A second biological agent that has gained attention as a possible bioterrorism tool is smallpox. According to the American Medical Association (AMA), when used as a biological weapon, smallpox represents a serious threat because of its fatality rate of 30% or more among unvaccinated persons. Although smallpox has long been feared as the most devastating of all infectious diseases, its potential for devastation today is far greater than at any previous time. Routine vaccination throughout the United States ceased more than 25 years ago. In a now highly susceptible, mobile population, smallpox would be able to spread widely and rapidly throughout this country and the world (AMA, 1999).

According to CDC, smallpox is a virus that has an incubation period of 12 days following exposure. Initial symptoms include high fever, fatigue, and head- and backaches that are then followed by a rash on the face, arms, and legs. The rash progresses into lesions that become pus-filled, turn into scabs, and eventually fall off. Smallpox is highly contagious and is spread by infected saliva droplets. While many patients with smallpox recover, death occurs in up to 30% of cases. There is no proven treatment for smallpox; however, a vaccine can lessen the severity of or prevent illness if given within 4 days of exposure (CDC, 2001b).

**Is the United States Prepared for a Bioterrorism Attack?**

On June 22–23, 2001, the Johns Hopkins Center for Civilian Biodefense Studies, in conjunction with the Center for Strategic and International Studies, the ANSER Institute for Homeland Security, and the Oklahoma National Memorial Institute for the Prevention of Terrorism, held an exercise at Andrews Air Force Base in Washington, DC, titled “Dark Winter.” The first such exercise of its kind, “Dark Winter” was constructed as a series of mock National Security Council (NSC) meetings in reaction to a fictional, covert smallpox attack in the United States (O’Toole & Inglesby, 2001).

The result of the drill highlighted several ar-
eas of concern with regard to governmental preparedness against bioterrorism attacks. First, there was a basic lack of understanding by leaders on the subject of bioterrorism. Second, early responses to the “attack” were slow to determine how many persons were “exposed,” and how many trained medical personnel would be needed. Also, the drill highlighted that the American health care system lacks the ability to deal with mass casualties, and there is a shortage of necessary vaccines and medicines. Finally, the “Dark Winter” drill indicated that conflicts between different levels of federal and state government and uncertainty in authority hampered responses (The Economist, 2001, pp. 29–30).

Due to the results of the “Dark Winter” drill and the September 11 attacks, lawmakers are trying to increase funding for various agencies to counter bioterrorism and its effects. In an effort to increase support, the U.S. House of Representatives passed fiscal 2002 spending bill for the departments of Education, Labor, and Health and Human Services (HR 3061-H Rept 107-229). This bill includes $393 million for measures to defend against biological or chemical attacks, which is an increase of $100 million in this area. Furthermore, the Senate bill (S 1536-S Rept 107-84) would allocate $338 million, and the House and Senate Armed Services committees have also greatly expanded biological defense and research efforts. The House’s fiscal 2002 defense authorization bill (HR 2586-H Rept 107-194) would fund chemical and biological defense procurement at $361.7 million. While the House bill would cut the administration’s request for chemical and biological weapons research and development by $5 million to $502.7 million, it would also increase spending for the Defense Advanced Research Projects Agency’s (DARPA) biological warfare defense program by $10 million to $150 million. The Senate’s defense authorization bill (S 1416-S Rept 107-62) would include similar increases for chemical and biological weapons programs as part of an overall boost of more than $600 million to deal with “nontraditional threats” such as terrorism and cyber attacks. The Senate bill would also direct the Defense Department to build a new facility to produce vaccines against anthrax and other biological agents (McCutcheon, 2001).

**Psychological Implications**

A central aspect of terrorism that should be examined is the psychological effect on the American people caused by acts of terrorism. Research on natural and human-caused disasters suggest that psychological reactions to terrorism are more intense and more prolonged than psychological reactions following natural types of disaster (Myers, 2001). Terrorist attacks, by their very nature, are designed to instill fear, anxiety, and uncertainty within a population (Badolata, 2001).

There are several characteristics of terrorism that can increase the magnitude and severity of psychological effects. First, terrorist attacks occur with a lack of warning that produces a disruption to society and people’s way of life. A lack of warning also prevents individuals from taking protective action, both physical and psychological. Terrorist attacks become more horrifying for individuals because there is usually a sudden change in reality and surroundings. For example, the New York City skyline changed in a matter of hours when the World Trade Center buildings collapsed and only a pile of smoking debris was left. Another psychological effect of terrorism is the threat to personal safety and security for both citizens and responders. Areas that were previously believed to be safe suddenly become unsafe. This feeling of insecurity can be instilled in an individual for an extended period of time. Acts of terrorism can also be traumatic because of the following elements: (a) the scope of their destruction, (b) the exposure by citizens, survivors, and responders...
to gruesome situations, (c) the emotional anger caused by the intentional human causalities, and (d) the degree of uncertainty, lack of control, and social disruption that a society is exposed to (Myers, 2001).

The September 11 attacks were different from other terrorist acts because of the magnitude and suddenness of the tragedy, the vast loss of life on American soil, the ability of citizens to follow the events of the attacks through extensive media coverage, and the use of airplanes, considered to be a common and “safe” mode of transportation, as a means of destruction (Dyer, 2001).

While every person who experiences a traumatic event responds to that event in different ways, there are many feelings and reactions that are common in the aftermath of a tragedy. These include sadness, anger, rage, fear, numbness, stress, feelings of helplessness, feeling jumpy or jittery, moodiness or irritability, change in appetite, difficulty sleeping, experiencing nightmares, avoidance of situations that are reminders of the trauma, problems concentrating, and guilt because of survival or lack of harm during the event (Dyer, 2001).

According to the National Center for Post Traumatic Stress Disorder, there are several steps that individuals can take in the wake of a disaster to reduce symptoms of stress and to readjust to some sense of normalcy. First, following a tragedy, an individual should find a quiet place to relax and attempt to sleep at least briefly. Next, there should be an evaluation of the situation where the survivor reaffirms priorities to establish hope and a sense of purpose. The survivor must also rely on the natural support of others such as friends, family, coworkers, and other survivors to establish a sense of togetherness and to help in the reduction of stress. Individuals should also try to engage in positive activities that can serve as a distraction from traumatic memories or reactions of the event. Finally, a person should seek out the advice of a doctor and/or counselor for help in treating symptoms of depression and/or post-traumatic stress disorder (National Center for Post Traumatic Stress Disorder, 2001).

Application of Roberts’ Seven-Stage Crisis Intervention Model as an Acute Post-Traumatic Intervention

Effective intervention with survivors of trauma precipitated by a crisis of this nature requires a careful assessment of individual, family, and environmental factors (Lewis & Roberts, 2002). According to Roberts (1990, 1991, 2000), a crisis by definition is short term and overwhelming, and the response will involve an emotionally taxing change. In terrorism, the crisis event has caused a senseless disruption within the individual’s normal and stable state. It makes sense that the individual’s usual methods of coping will not work and a quiet place must be established, allowing the individual to think, ponder, and regroup.

Roberts (1991) has presented a seven-stage crisis intervention model that includes: (a) assessing lethality and safety needs, (b) establishing rapport and communication, (c) identifying the major problems, (d) dealing with feelings and providing support, (e) exploring possible alternatives, (f) formulating an action plan, and (g) providing follow-up. In the process, counselors need to remember that both pleasure and pain are a necessary part of growth and adaptation. Individuals who have experienced a crisis must realize that both emotions can coexist as well as fluctuate throughout the healing process. Early intervention for the individual in crisis can lead to a more rapid and effective adjustment.

When applying Roberts’ model, the following assumptions are made: (a) all strategies will follow a “here and now” orientation, (b) most in-
Interventions provided should be given as close to the actual crisis event as possible (Raphael & Dobson, 2001; Simon, 1999). (c) the intervention period will be both intensive and time limited, typically 6 to 12 meetings (Roberts, 1991, 2000). (d) the survivor’s behavior in relation to stress is an understandable, rather than a pathological reaction (Roberts & Dziegielewski, 1995). (e) the crisis counselor will assume both an active and directive role assisting the survivor in the adjustment process, and (f) all intervention efforts are designed to increase the survivor’s remobilization and return to the previous level of functioning (Dziegielewski, 1998; Dziegielewski &
Resnick, 1996). These assumptions must be considered before applying Roberts’ model during crisis intervention.

**Stage 1: Assessing Lethality**

The unpredictability of terrorist attacks and the fear of further attacks make recovery from this type of acute trauma particularly problematic. Also, other events that happen in the environment are more likely to be perceived as terrorist activity, regardless of actual cause. This makes it more difficult for the survivor to progress past the active danger phase. Listed below are some of the hazardous events or circumstances that can be linked to the recognition or reliving of traumatic terrorist events. These events, while possibly unrelated to terrorist activity, can still trigger anxious responses from individuals. These events can include: (a) growing public awareness of the prevalence of the traumatic event or similar traumatic events (e.g., an accidental plane crash with subsequent loss of human life or incidents related to bioterrorism in the environment), (b) the acknowledgment by a loved one or someone that the client respects that he/she has also been a victim, (c) a seemingly unrelated act of violence being committed to them or someone they love such as rape and/or sexual assault, (d) the changing of family or relationship support issues, and (e) the sights, sounds, or smells that trigger events from the client’s past (these can be highly specific to individuals and the trauma experienced). Thus, when dealing with trauma, the sensitivity thresholds and the memories as to cues associated with the individual’s interpretation process can vary (Wilson, Freidman, & Lindy, 2001).

One of the immediate dangers in Stage 1 is the possibility of suicidal tendencies. With the seriousness and unpredictability related to terrorist acts, any intervention efforts will require careful assessment of suicidal ideation. In addition, initial and subsequent hospitalization and/or medication may be required to help deal with serious episodes of anxiety and depression surrounding the event. Although no individual wants to experience pain, some professionals believe that a moderate degree of pain is needed to facilitate the healing process. Therefore, medications should be used with individuals in the most severe cases or as conjunct to intervention, rather than as a means to simply avoid dealing with uncomfortable feelings (Dziegielewski, 2002; Dziegielewski & Leon, 2001).

When addressing the potential for suicidal behavior, questions to elicit signs and symptoms of suicidal ideation or intent should be direct in nature. The client should be asked about feelings of depression, anxiety, difficulties in eating or sleeping, psychological numbing, self-mutilation, flashbacks, panic attacks or panic-like feelings, as well as increased incidences of substance use. After carefully identifying the degree of loss experienced by the individual, the individual’s living situation needs to be assessed based on the age and the circumstances of the trauma experienced. Helping the client identify members of his or her support system will help to assure the client that he/she is out of danger, as well as remind the client of support that remains immediately accessible.

The initial contacts the crisis worker has with the client in crisis should be individualized, structured, and goal oriented to assist the individual to move past the traumatic event. It is critical for the crisis counselor to help the client understand that the traumatic terrorist event was beyond his or her personal control.

In these initial meetings (Meetings 1–3), the goal of the therapeutic intervention is to identify the hazardous event and help the client to acknowledge the event. In addition, when dealing specifically with terrorism, the client must be made aware that other seemingly unrelated
events might also trigger a similar panic-like response. Once aware that panic symptoms may reoccur, specific preparation needs to be made as to how to handle these occurrences and subsequent feelings. Since the client is currently being subjected to periods of stress that disturb his or her sense of equilibrium, attempts to maintain or restore the homeostatic balance can be commonplace.

Crisis counselors should understand that the dynamics often following a crisis situation could be so overwhelming that the client may choose to focus on events other than the crisis event. If this happens, the crisis counselors must help the client focus on the problem (i.e., the event that precipitated the crisis or the reason for the visit). During these initial meetings, the client realizes and acknowledges that the crisis or trauma has occurred. Once this is realized, the client enters into a vulnerable state (Roberts & Dziegielewski, 1995). The impact of this traumatic can be so horrific that it disturbs the client, and his or her ability to utilize traditional problem-solving and coping methods. When these usual methods are found to be ineffective, tension and anxiety continue to rise, and the individual becomes unable to function effectively (Roberts, 2000).

In the initial meetings, the assessment of the client’s past and present coping behaviors are important; however, the focus of intervention must remain in the “here and now.” The crisis counselor must make every effort to stay away from past or unresolved issues unless they relate directly to the handling of the traumatic event.

Stage 2: Establishing Rapport and Communication

Many times the devastating events that surround the immediate and unforeseeable loss of a loved one may leave the survivor feeling as though family and friends have abandoned him or her, or that they are being punished for something they did. Crisis counselors need to be aware that these types of unrealistic interpretations may cause the client to feel overwhelming guilt. Feelings of self-blame may limit the client’s capacity for trust, which may be reflected in a negative self-image or poor self-esteem. Low self-image and poor self-esteem may increase the individual’s fear of further victimization. Many times, survivors of trauma question their own vulnerability and realize that revictimization remains a possibility. This makes the rapport between counselor and client essential.

When possible, the crisis counselor should progress slowly and allow the client to set the pace of intervention attempts. Coercion and forced confrontation may not be helpful. Allowing the client to set the pace creates a trusting atmosphere that sends the message, “The event has ended; you have survived and you will not be hurt here.” Clients often need to be reminded that their symptoms are a healthy response to an unhealthy environment (Dziegielewski & Resnick, 1996). They need to recognize that because they have survived heinous circumstances, they must continue to live and cope. The trauma victim may require a positive future orientation, with an understanding that he or she can overcome current problems and arrive at a happy, satisfactory tomorrow (Dolan, 1991). Restoring hope is crucial to the client’s well-being.

Unconditional support and positive regard must be maintained throughout the crisis intervention process. This is especially crucial between the counselor and client in order to avoid lack of support, “blaming,” and breach of loyalty, which are common within the working relationship between counselor and clients. The therapeutic relationship is seen as a vehicle for continued growth, development of coping skills, and the ability to move beyond the traumatic event (Briere, 1992).
**Stage 3: Identify the Major Problems**

Terrorist attacks can be multifaceted. Once the major problems relevant to the particular event are identified and addressed, the establishment of support mechanisms becomes essential. After a client has been given individual attention, he or she may be ready for group participation. In crisis work, emphasis should be placed on teaching relaxation techniques, encouraging physical exercise, and creating an atmosphere where the client gains an understanding that self-care is at the root of all healing. This provides the basis for future coping and stabilizing efforts.

In these next few meetings (Meetings 3–6), the crisis counselor needs to assume a very active role. First, the major problems must be identified. These problems must be directly related to the effects of responses and actions upon the present situation. Education in regards to the effects and consequences of terrorism should be discussed. Discussing the event can be very painful for the client, and simply reacknowledging the event can elevate the individual to a state of active crisis marked by disequilibrium, disorganization, and immobility (e.g., the last straw). Although the client’s acknowledgment of the event may be painful, it will generate new energy for problem solving. This challenge stimulates a moderate degree of anxiety, in addition to hope and expectation. The actual state of disequilibrium can vary, but it is not uncommon for individuals who have suffered severe trauma to remain in that state for 4 to 8 weeks or until some type of adaptive or maladaptive solution is found.

**Stage 4: Dealing With Feelings and Providing Support**

This process is steered by the energy generated from the client’s personal feelings, experiences, and perceptions (Briere, 1992). It is critical that the crisis counselor demonstrate empathy and an understanding of the client’s worldview. The symptoms the client is experiencing are to be viewed as functional and as a means of avoiding further abuse and pain. Even severe symptoms, such as dissociative reactions, should be viewed as a constructive method of removing oneself from a harmful situation and exploring alternative coping mechanisms. The experiences of the client should be normalized to facilitate the understanding that victimization is not their fault. Reframing symptoms are coping techniques that can be helpful. In this stage (Meetings 6–8), the client begins to reintegrate and gradually reaches a new state of equilibrium. Each particular crisis situation (i.e., type and duration of incest, rape, etc.) may follow a sequence of stages, which can generally be predicted and mapped out. One positive result from generating the crisis state in Stage 3 is that in treatment, after reaching active crisis, clients seem particularly amenable to help.

Once the crisis situation has been obtained, distorted ideas and perceptions regarding what has happened need to be corrected so that the client can better understand what he or she has experienced. Victims eventually need to confront their pain and anger so that they can develop better strategies for coping. Increased awareness helps the client face and experience contradicting emotions (e.g., anger/love, fear/rage, dampening emotion/intensifying emotion) without the conditioned response of escape (Briere, 1992). Throughout this process there must be recognition of the client’s continued courage in working through these issues.

**Stage 5: Exploring Possible Alternatives**

Moving forward requires experiencing a mourning process (generally in Meetings 8–10). Sadness and grief over the loss needs to be experienced. Expressions of grief regarding be-
trayal and lack of protection open to the client a spectrum of feelings that have been previously numbed. This stage allows the client to experience acceptance and letting go so that making peace with the past may begin.

**Stage 6: Formulating an Action Plan**

In the sixth stage, the crisis worker must be very active in helping the client determine how the goals of the therapeutic intervention will be completed. Many techniques are used to address intervention planning such as practice, modeling, behavior rehearsal, role play, and the writing down of an action plan along with one’s feelings. Often, the client has come to the realization that they are not at fault or to blame. The doubt and shame of what his or her role was and what part he or she played becomes more clear and self-blame less pronounced. The client begins to acknowledge that they did not have the power to help themselves or to change things related to the event. Oftentimes, however, these realizations are coupled with anger at the lack of control over what has happened. In this stage, the role of the mental health professional becomes essential in helping the client look at the long-range consequences of acting on their anger and to plan an appropriate course of action. The main goal of these last few sessions (Meetings 10–12) is to help the client reintegrate the information learned and processed into a homeostatic balance that allows him or her to return to a state of normalcy. Referrals for additional therapy should be considered and discussed at this time (e.g., additional individual therapy, group therapy, couples therapy, family therapy).

**Stage 7: Follow-Up Measures**

While Stage 7 is often overlooked, it is very important to the process of intervention in general. In the successful therapeutic exchange, significant changes have been made for the client in regard to his or her previous level of functioning and coping. Measures to determine whether these results have remained consistent are essential. Oftentimes follow-up can be as simple as a phone call to discuss how things are progressing. Follow-up within 1 month of termination of the sessions is important. It may also be helpful to suggest that debriefing or intervention be addressed to help the client reach a higher level of adjustment (Everly, Lating, & Mitchell, 2000; Raphael & Dobson, 2001). It is important not to push the client beyond the point that he or she is willing to go. In addition, the client may need the time to self-recover, which could lead to willingness for further intervention.

Other measures of follow-up are available but require more advanced planning. A pretest/posttest design can be added by simply using a standardized scale at the beginning of treatment and later at the end (Dziegielewski & Powers, 2000). Scales to measure the signs and symptoms of psychological trauma are readily available. See Corcoran and Fischer (1994) for a thorough listing of measurement scales that can be used in the behavioral sciences.

Finally, it is important to realize that when dealing with this type of stress reaction, the determination of the course and type of intervention will always rest with the client. At follow-up, many clients may need additional therapeutic help, yet may be unable to express the request for a debriefing session. Whereas others, after having initially adapted to the crisis and learned to function and cope, may find that they want to continue some type of intervention. Supporting the client as he or she progresses through the crisis period remains the ultimate goal of any crisis intervention. Whether the client requests additional services or not, the crisis counselor should be prepared to present available options for continued therapy and emotional growth. If additional intervention is requested, referrals for group therapy with
other survivors of similar trauma, individual growth-directed therapy, couples therapy that is to include a significant other, and/or family therapy should be considered.

**Future Directions: Where Do We Go From Here?**

The tragic events of September 11, 2001, changed America forever. Terrorism, in its various forms, has exposed, on a national scale, the need for tighter security at the nation’s borders as well as continued efforts to ensure protection from biological warfare (Eisenburg, 2001). Questions arise, such as how can Americans once again feel safe after the September 11 attacks? Furthermore, whether directly exposed to terrorist activity or not, the fear of terrorism can affect everyone.

With so many people being directly affected by terrorism, and many more suffering the by-products of living in an unpredictable environment, the issue of crisis counseling to address stress and coping has gained significant attention. This increased attention has lead to a rapid increase in many theoretical, evidence-based measures, models of critical incident stress debriefing, and other related materials such as professional journals devoted to research in this field and books and related materials for the general public (Lewis & Roberts, 2002; Spitzer, 2002, Wilson et al., 2001). Recent events have lead some researchers to claim that coping with trauma and stress has become a socio-cultural phenomenon, which might result in higher self-reported stress levels due to the proliferation of information about stress in the popular culture (Moss & Lawrence, 1997).

The recent experiences of terrorism and the ways to cope with the resulting trauma and stress remain diverse. Levels of stress that these survivors experience, the sources of stress, stress related to self-esteem and self-perception, stress and coping skills, and how to best handle stressful situations are just a few of the many issues that need to be researched further. The violence caused by the recent turn of events starting with the incident on September 11, 2001, remains unprecedented in American history. The American people have traditionally been expected to adjust to new social environments, maintain good personal and occupational standing, and face pressures related to supporting friends and family. Survivors of trauma need to continue to develop new roles and modify old ones in response to the developmental tasks they face. More attention needs to be given to understanding crisis and the responses that will occur initially and those that will continue to resurface after the initial phase of the trauma has passed. The threats of terrorist attacks can have considerable psychological effects from immediate responses to those that are prolonged or delayed in nature (DiGiovanni, 1999). More information is needed as to when is the most effective time to address a stressful event (Raphael & Dobson, 2001). Coping and stress management techniques can help an individual return to a previous level of functioning, where healthy individuals who have been exposed to extreme trauma can receive the health and support needed.

**References**


