What We Learned From 9/11: A Terrorism Grief and Recovery Process Model

Karin Jordan, PhD

This article presents a terrorist grief and recovery process model of 3 stages: Stage I: Disequilibrium—the Immediate Aftermath; Stage II: Denial—Outward Adjustment; and Stage III: Integration—Coming to Terms. Protective factors, such as stress buffers and resiliency, are focused on, and personal factors, which include but are not limited to age, gender, and ethnicity, are also discussed. Predisposing factors (e.g., psychiatric histories, previous trauma, and educational disadvantages), peridisposing factors (e.g., proximity and duration of exposure to the terrorist attack), and postdisposing factors (e.g., family and other support systems) are also described. All these factors are believed to influence the grief and recovery process. After a terrorist attack such as that on the World Trade Center on September 11, 2001, people’s beliefs are often impacted, specifically beliefs held about (a) the world as they knew it, (b) human nature, (c) spirituality, and (d) themselves, because their inner world cannot continue in the same way as before the attack, so they must go through some transformation in order for them to “find their place” and reintegrate themselves into the world. For many, this requires a grief and recovery process. Although many will need to assimilate or accommodate new values, some will be able to return to their old values and beliefs. Others might “get stuck,” unable to deal effectively with the terrorist attack and its impact. [Brief Treatment and Crisis Intervention 5:340–355 (2005)]

KEY WORDS: terrorism, 9/11, grief, recovery process, trauma, PTSD, traumatology, World Trade Center.

I was at work, when one of my colleagues frightfully reported that a plane had crashed into the World Trade Center. I still can hear each word clearly in my mind. “Oh my god.” I thought, “My mom works there.” I had to get over there. I realized that I didn’t even know what she (mom) was wearing today. What if she was injured, and somebody needed to identify her? I could not allow myself to even think that she might be dead. (Pause) I got angry with myself, because as my mom said good-bye that morning, I was still in bed, and never even opened my eyes, nor did I say good-bye. My mind was racing.
(Pause) Will I ever again say good-bye to her? I felt overcome with anger about my uncaring. Why did I not say good-bye? Why did I not even open my eyes? Not even for just a second? I thought if I had, then I would know what she was wearing today. (Pause) Weird, huh? (Pause) Yeah, I somehow found myself outside the building, running toward the World Trade Center. (Pause) I have no idea how I got down to the street. When I finally reached 23rd Street, it seemed that everyone was trying to get uptown. My God, the sidewalks were overflowing with hundreds and hundreds of people. I was half walking and half running, as were others. Then we saw it, a plane stuck in the building. (Pause) That was the building my mom worked in. (Pause) Oh my god, I was horrified. Nothing felt real to me at that moment. The magnitude of the situation seemed way too overwhelming. (Pause) I could barely grasp what happened, it seemed so unreal . . . . (A New Yorker, 2001, 10 days after 9/11)

According to Ozer, Best, Lipsey, and Weiss (2003), most people are exposed to violent acts and/or life-threatening situations at least once throughout their lives. These frequencies increase in situations of mass destruction when there are multiple deaths, injuries, and destruction of buildings, as often experienced in terrorist attacks. On September 11, 2001, a terrorist attack on the World Trade Center resulted in the bereavement of 15,000 children (many of whom came from single-parent homes) who suddenly lost a father or mother (Webb, 2002). The attack caused 2,471 deaths (Webb, 2002), including those of several hundred police officers and firefighters, as well as 189 at the Pentagon, 246 in the four hijacked planes, and the 19 hijackers (Webb, 2002). How many escaped death that day is unknown. In New York alone, there were well over 100,000 people who directly witnessed what happened and tens of thousands who ran for their lives, often barely escaping death. Many, many more helplessly watched the terror from close proximity (Schuster et al., 2001). Many others, all around the world, were exposed to the horrifying pictures via the news media (Schuster et al., 2001).

Over the last decade, the field of traumatology has grown rapidly, with leaders such as Charles Figley, Sarah Haley, Mardi Horowitz, Terence Keane, Bob Laufer, Richard Mollica, Bob Pynoos, Raymond Scurfield, Susan Solomon, Bessel van der Kolk, Mary Beth Williams, and John Wilson. The foci of their work, and those of others, have been the physiological impact of trauma (Rothschild, 2000; van der Kolk, 1994); the psychological impact of trauma (Jordan, 2004); Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD); treatment methods (e.g., Critical Incident Stress Debriefing, individual intervention, defusing, Crisis Management Briefing, demobilization and staff consultation, and precrisis preparation; Everly & Mitchell, 1999); treatment assessment (Roberts, 2000); treatment intervention (e.g., the trauma genogram; Jordan, 2004); Eye Movement Desensitization and Reprocessing (Shapiro, 1995); and treatment modalities (e.g., individual, couple, family, and group; Everly & Mitchell, 1999). Terrorism and its effects are still relatively unresearched in this country, as terrorism is a new phenomenon in the United States. This article is devoted to the terrorism grief and recovery process model and factors that might influence the grief process and the recovery process. More specifically, for the purpose of this article, the stages of recovery after the terrorist attack on the World Trade Center have been focused on.

Terrorism is a particular form of trauma. It can be defined as a single, short-term, and relatively brief but extreme exposure or as
a long-term, repeated or prolonged exposure to an extreme and powerful threat resulting from an identifiable stimulus or catalyst event characterized by overwhelming an individual’s customary coping skills and sense of safety and security. Terrorist attacks generally include an “extreme and powerful threat” and perhaps actual injury to the physical and emotional integrity of self or others and can involve injury and death. They can also involve the loss of resources, such as jobs and homes, as was seen in New York after 9/11. Many will be overwhelmed emotionally and psychologically. Typically, the goals of terrorism are to make a political statement and “to disconnect people from resourceful positive states of consciousness and to connect them instead to non-resourceful fearful states of consciousness” (Schwarz, 2002, p. 241). Terrorist attacks often result in unbalancing relationships (family, family subsystems, couple) or in changed parenting (by being either overprotective or abusive and neglectful). It is therefore important to remember that a time “of psychological disequilibria, experienced as a result of a hazardous event or situation that contributes a significant problem cannot be remedied by using familiar coping strategies” (Roberts, 2000, p. 7). Terrorist attacks, as well as threats of terrorism, can have a variety of impacts on people, from minimal to acute distress, and even debilitating effects on individuals, families, communities, and whole nations, disrupting people’s behavior, cognition, and psychological well-being. Those exposed to the terrorist attack face increased risk of developing PTSD, described by Brewin (2004) as “(1) a failure of normal adaptation to a traumatic event, (2) extreme fear, helplessness, or horror experienced at the time or later, (3) in part it is a general response to any adverse event, and (4) in part it is a specific response involving memory (e.g. flashbacks) and identity (e.g. dissociation)” (p. 4). Others might develop major depression, panic disorder, generalized anxiety disorder, and substance abuse (Kessler, Sonnega, Bromer, Hughes, & Nelson, 1995) or “somatic symptoms and physical illness such as hypertension, asthma, and chronic pain syndrome” (Yehuda, 2002, p. 108). People’s responses may be minimized or exaggerated, acute or chronic, according to the severity, magnitude, and duration of the attack. Some people seem to be less affected and are able to endure the experience remarkably well, with little apparent disruption in their interpersonal relationships and emotional and behavioral level of ability functioning. Others are often more severely impacted, for example, those with risk factors, such as previous trauma and psychiatric history, as well as those directly affected by the terrorist attack, who have experienced the threat and the degree of imminent danger to self or others (ranging from injury to possible death) with no defense or escape. Most will gradually recover from acute distress, although some seem to never do so. Recovery can best be described as adapting using customary, adapted, or new coping strategies in an attempt to return to their normal (preterrorist attack) functioning.

The attacks on the World Trade Center and the Pentagon and the accompanying loss of thousands of lives affected tens of thousands of people who feared for their lives or for those around them, were exposed to graphic scenes of death and injury, or lost loved ones, friends, and colleagues (Yehuda, 2002). Following the terrorist attacks were many additional threats of terrorism, including the prospect of and eventual engagement in war, as well as threats of bioterrorism (Yehuda, 2002). Not only were civilians affected but also were rescue workers as they were directly involved in the prolonged aftermath of the terrorist attack. Many of these rescue workers were affected through direct life threat and/or directly witnessing the event, the loss of colleagues, seeing graphic death
scenes and horrifying sights and smells, and transitioning their efforts quickly from rescue to recovery efforts. All those affected, civilians and rescue workers alike, will most likely go through a process of assessing their old values and beliefs about themselves, the world around them, spirituality, and human nature. Additionally, the belief that terrorism will not strike the United States can no longer be held on to. Finally, people feel a need to attribute a cause to the terrorist attack and deal with the fear, helplessness, and horror associated with it. Many, in an attempt to make sense of the experience because they cannot tolerate the disequilibrium indefinitely, will need to find some means to restore a sense of internal organization and stability.

Although it is important to achieve some stability, constructive resolution of the terrorism may require either (a) integrating (assimilating) the experience into their existing values and beliefs about themselves, the world around them, spiritual beliefs, and human nature as they knew it or (b) accommodating their beliefs and values by developing new ones about the world, human nature, spirituality, and themselves. Some, however, will neither assimilate nor accommodate old values and beliefs but will appear as if they had returned to their lives prior to the terrorist attack. They may, however, present with unexplained physical symptoms and psychological responses. Resilient individuals might use the terrorist attack as a psychic reorganizer, an opportunity to assess life and make positive life changes. For most, however, it was a time of disorientation as they grieved the loss of lives, property, and values and beliefs once held. Grief cannot, therefore, be ignored, as it is apparently strongly associated with terrorist attacks.

In the same way that terrorist attacks and grief issues are inseparable, so are the fields of traumatology and thanatology. (Traumatology is the study of trauma, and thanatology is the study of death.) Today, models such as Kubler-Ross’ (1969) five-stage grief model (denial, anger, bargaining, depression, and guilt and acceptance) cannot be blindly adapted to terrorism-related grief due to the limited empirical research in this area thus far (Wortman & Silver, 1989). Other models of grief need to be explored closely and should not be blindly accepted as being representative of a terrorist grief and recovery process model. Most existing grief models identify grief as a normal process of experiencing the psychological, emotional, social, and physical reactions to the experience of loss, which generally relates to the loss of a person (Van Ornum & Mordock, 1990; Rando, 1988). Grief can best be described as the “intrapsychic process of regaining equilibrium after the loss,” whereas bereavement is a “general state of being resulting from experiencing a significant loss” (Cook & Dworkin, 1992, p. 6). As there seems to be a connection between terrorism and grief as both are dealing with loss, it is important to assess if there are overlapping and unique symptoms associated with terrorism and grief issues.

Table 1 illustrates how terrorism symptomology compares to grief symptomology. Table 1 clearly identifies that there are distinct, as well as overlapping, symptoms that support the idea that terrorism and grief should be viewed as connected and similar, yet uniquely different and distinct. Therefore, when looking at the impact of terrorist attacks, grief cannot be ignored; therefore, it is important to make use of both the resources and literature in the fields of traumatology and thanatology.

When looking at the impact of terrorist attacks, individual differences, known as “personal factors,” such as personal, familial, and cultural history (Nader, 1994), as well as spiritual beliefs and values (Hettler & Cohen, 1998; Woodcock, 2001), age, gender, socioeconomic status, physical, psychological (Pine & Cohen, 2002) and relational histories, along
with community practices and resources, cannot be ignored. Each person’s response will be somewhat different, and most likely will impact the way he or she copes with and resolve the terrorist attack and the related grief issues through assimilation and accommodation. Important additional factors known as ‘‘predisposing factors,’’ ‘‘peridisposing factors,’’ and ‘‘postdisposing factors’’ need to be considered when responding to terrorist attacks.

One of these additional factors, predisposing factors, includes (1) past experiences of trauma (e.g., previous exposure to aggression and violence [actual and vicarious, chronic and acute; Epps, 1997, p. 49]) and trauma reactions (e.g., dissociative reactions [Brewin, Andrews, & Valentine, 2000]); (2) suicidal and/or homicidal ideations (e.g., suicidality is often associated with feeling overwhelmed and hopeless, whereas homicidity is generally the result of anger and rage such as revenge and ‘‘somebody has to pay’’); (3) guilt and/or a sense of responsibility (e.g., the preoccupation of preventing the event and the potential of later harm to the victim and the inability to convince the victim that he or she could not have done anything to prevent the situation from happening [Nader, Pynoos, Fairbank, Al-Ajeel, & Al-Asfour, 1993]); (4) previous losses ([a] multiple losses [e.g., losses through death of a loved one; loss of a sense of safety and security through threats to one’s own life and life path; and loss of various aspects of the self, such as humor, self-confidence, sense of safety, security, self-reliance, and independence], (b) previous losses [e.g., current horrible memories,
flashbacks, and dreams], and [c] past unresolved traumatic losses [Pynoos & Nader, 1989]; and (5) low intelligence and lack of education (Brewin et al., 2000; Ozer et al., 2003). Wiger and Harowski (2003) identified these additional possible predisposing factors: ‘‘(1) personality disorders, (2) poor coping abilities and strategies, (3) difficulty learning from previous experiences, (4) low self-esteem, (5) unstable work history as well as lack of finances, (6) chemical dependency, (7) legal problems, (8) chronic mental health issues (e.g., obsessive compulsive disorders, anxiety disorders, paranoia, PTSD, depression), (9) past and/or present legal problems, (10) impulsivity, and (11) all or nothing thinking.’’ (pp. 50–51). All the above predisposing factors, according to Parade (1965), lead people to be ‘‘crisis prone individuals’’ as they often possess poor coping skills. Peridisposing factors include proximity to and duration of exposure to the terrorist attack; perceived threat to safety of self and others, including possible injury or loss of life; extreme fear, helplessness, and horror during a terrorist attack; dissociation; and subjective terrorist attack interpretation.

Postdisposing factors include (a) family, friends, and other support; (b) initially available and accessible resources; (c) educational material such as information about normal reactions after a terrorist attack; (d) intervention services such as psychological debriefing (as long as it is not used as a blanket intervention, but only after careful initial screening; Mitchell & Everly, 2000), (e) counseling for those individuals with risk factors, such as prior trauma, low social support, and more long-term PTSD (Yehuda, 2002); and (f) medications, such as selective serotonin-reuptake inhibitors (Davidson, Rothbaum, van der Kolk, Sikes, & Farfel, 2001), tricyclic antidepressants (Davidson, Kudler, & Smith, 1990), and monoamine oxidase inhibitors (Kosten, Frank, Dan, McDougle, & Giller, 1991).

There are also protective (psychological) factors (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000) that include both stress buffers (such as hardiness [e.g., Florian, Mikulincer, & Taubman, 1995], self-enhancement [e.g., Bonanno, Field, Kovacevic, & Kaltman, 2002], positive emotion and laughter [e.g., Bonanno, Noll, Putnam, O’Neill, & Trickett, 2003], etc., which are not contingent on the occurrence of a terrorist attack) and resiliency (the individual’s ability to cope, bounce back, and keep on growing, emotionally and psychologically, in challenging and traumatic situations such as a terrorist attack). Predisposing factors are believed to be consistent but weak predictors of adjustment after a terrorist attack, whereas peridisposing and postdisposing factors are stronger predictors of adjustment after a terrorism attack. They are also idiosyncratic and involve intrusive questioning (Brewin, 2004). Protective (psychological) factors can serve as protective mechanisms from developing ASD and PTSD. Although a person may meet the diagnostic criteria for ASD within the first month after a terrorist attack, this does not mean that he or she will also develop PTSD. Instead, it is believed that those with ASD are at higher risk of developing PTSD than those without ASD. However, as described previously, personal factors, predisposing factors, peridisposing factors, postdisposing factors, and protective factors will influence whether a person will develop PTSD, which means that terrorist attacks may, but not necessarily will, lead to PTSD, as has been supported by several studies (Yule, 2001). One study reported that 44% of people in the United States were dealing with at least one (out of five) PTSD symptom in the first 3–5 days after the terrorist attack on September 11, 2001 (Schuster et al., 2001). In another study that involved a web-based epidemiology survey, an estimated 11.2% of New Yorkers (in the metropolitan area) presented with a PTSD.
prevalence (Schlenger et. al., 2002). Additionally, it was reported that PTSD prevalence was estimated to be three times higher in New York City than for people in other parts of the United States (Galea, Ahern, et al., 2002).

In that study, the impact of the terrorist attack on New Yorkers has been assessed empirically through a population-based survey given to New Yorkers 1, 4, and 6 months after September 11 (Galea et al., 2002). The results indicated that an estimated 7.5% of Manhattan (south of 110th Street) residents would meet the criteria for PTSD. According to the same study, another 17.4% meet the criteria for subsyndromal PTSD (the symptoms are high but do not fully meet the PTSD criteria), whereas over 40% of Manhattan residents did not report one single PTSD symptom. Four- and six-month follow-up studies indicated a rapid decline of symptoms (Galea et al., 2003). The prevalence of meeting PTSD criteria after 4 months dropped to 1.7% and after 6 months to 0.6%, whereas the prevalence of subsyndromal PTSD dropped to 4.0% 4 months after September 11 and after 6 months was slightly elevated to 4.7%. None of these data include delayed PTSD, which includes approximately 5–10% of trauma exposed individuals (Buckley, Blanchard, & Hickling, 1996) and would somewhat raise the percentages reported by Galea et al. (2002, 2003). These findings support the belief that the symptoms experienced by persons after a terrorist attack will, for most, be temporary and a reflection of the person’s capacity to adapt in the face of terrorism as it is believed that many of the symptoms experienced after a terrorist attack should be viewed as a normal reaction to an abnormal event (Mitchell & Everly, 2003).

Only a small percentage of people described previously, generally related to personal factors, predisposing factors, peridisposing factors, postdisposing factors, might develop PTSD because the terrorist attack is so debilitating to them that they cannot, even over time, restore a sense of order and stability and regain equilibrium.

It appears that “some individuals will be able to return to the status quo after a traumatic event” (Jordan, in press, p. 16), whereas for resilient individuals, the terrorist attack can serve as a psychic reorganizer (Holloway & Ursano, 1984). However, many people after a terrorist attack experience some disequilibrium in their basic beliefs (Pearlman & Saakvitne, 1995) about (a) the world (that it is safe, benevolent, just, and predictable), (b) human nature (that people have good intentions and motivations), (c) spirituality (feeling connected with some higher power and that the meaning of life is impacted by the higher power), and (d) themselves (their own ability to regulate the inner self as well as to be introspective, strive for personal growth, protect themselves or others, be intimate with self, be affective, and have good self-esteem). This disequilibrium exists as people attempt to make sense out of the terrorist attack and incorporate it in their existing values and beliefs. Some people will be able to accommodate their old values and beliefs and achieve equilibrium once more. In situations when equilibrium cannot be achieved through accommodation, the terrorist attack is incomprehensive and cannot be incorporated into previously held beliefs and values, and the person will need to go through the process of assimilating. This means developing new values and beliefs about (a) the world, (b) human nature, (c) spirituality, and (d) themselves, in an attempt to achieve equilibrium once more. In situations when neither accommodation nor assimilation of values and beliefs can be achieved, individuals would most likely present with extensive psychic impairment. As described previously, individual factors, predisposing factors, peridisposing factors, and postdisposing factors as well as protective factors will all influence people’s ability to achieve equilibrium (Eaton & Roberts,
When considering all the various factors that influence people’s ability to reach equilibrium after a terrorist attack, one must not minimize the importance of the grieving process. According to Cook and Dworkin (1992), the grieving process is the “intrapsychic process of beginning equilibrium after the loss” (p. 6). After a terrorist attack, this is a complex process that is influenced by personal factors, predisposing factors, perdisposing factors, postdisposing factors, and protective factors and involves the intrapsychic process of adjusting or changing existing values and beliefs about the world, human nature, spirituality, and themselves through accommodation or assimilation. It also is a relatively long-term, multidimensional (emotional, behavioral, and psychological) response, as well as an interpersonal and social functioning response.

The grieving and recovery process after a terrorist attack should be viewed as a normal process that requires mental health services only when individuals meet PTSD criteria or are struggling with chronic PTSD and severe levels of grief. The model described subsequently can serve as a guide for those directly or indirectly affected by a terrorist attack. It does not encourage mental health services for resilient and recovering persons as the grief and recovery process after a terrorist attack should be perceived as a normal process and a way to regain equilibrium. The model should be perceived as a guideline and not as a definite step-by-step process that people affected by the terrorist attack on the World Trade Center had to go through.

**The Terrorist Grief and Recovery Process Model**

The terrorist grief and recovery process model is based on the belief that many people who experienced the terrorist attack on the World Trade Center needed to work through the experience (e.g., visual images), thoughts, and emotions associated with it, with particular emphasis on potential threats to their own safety and lives, as well as those of loved ones, friends, peers, and colleagues. Part of the grieving and recovery process is relinquishing an attachment to previously held beliefs and values about themselves, human nature, the world, and spirituality. Those who have lost loved ones, friends, peers, or colleagues will also need to relinquish the attachment bond to the deceased and often deal with traumatic grief.

The terrorist grief and recovery process model is made up of three stages, which are not necessarily experienced in an orderly fashion. Most people move back and forth between stages, especially when additional threats are made during times of additional terrorism, other trauma and loss, terrorist anniversaries, and extensive media coverage, before they reach resolution. Many people will be able to move through the grief and recovery process, whereas others who are unable to resolve the grief issues will never fully achieve moving through all three stages. It is unclear if those who are unable to fully work through these stages may be those with greater post-traumatic distress (Resick, 2001). Additionally, individuals with a trauma history, who have developed coping skills such as disassociation, may resort to these familiar coping skills instead of going through the stages of grief. Those with delayed PTSD may also appear to not go through a grieving and recovery process. There might be an emotional avoidance of awareness. Those individuals who are unable to resolve the grief and recovery process are often individuals who self-reported higher levels of depression and negativity than those who were successful in moving through the grieving and recovery process.
The terrorist grief and recovery process model presented in this paper was developed based on the belief that there is an interrelatedness between the individual’s (a) personal factors, (b) predisposing factors, (c) peridisposing factors, (d) postdisposing factors, and (e) protective factors. It is important to keep in mind that because these variables are all interrelated, they should all be considered when looking at the terrorism grief and recovery process model. The following section delineates a terrorist grief and recovery process through three stages based on the author’s work with New Yorkers 1 week, 3 months, and 1 year after the terrorist attack on the World Trade Center.

The three stages of the terrorist grief and recovery process model are Stage I: Disequilibrium—The Immediate Aftermath; Stage II: Denial—Outward Adjustment; and Stage III: Integration—Coming to Terms. This model should be viewed as providing general guidelines, not as a blueprint, because individual personal factors, predisposing factors, peridisposing factors, postdisposing factors, and protective factors are all believed to impact how people will cope with the terrorist attack on the World Trade Center. For some, avoidance, dissociation, or deferment of emotions may potentially serve as a temporary adoptive function. For many others, the self-regulating process of accommodation and assimilation are used to cope. Accommodation can best be described as the process of incorporating new experiences, beliefs, and values into existing values and beliefs about the world, human nature, spirituality, and themselves. Assimilation is used to ascribe new meaning, as well as cognitively restructure old values and beliefs about the world, human nature, their faith belief system (if they have one), and themselves. Both accommodation and assimilation served as ways for individuals to make sense of the terrorist attack on the World Trade Center and to move on in their grief and recovery process. Finally, resilient individuals, as described earlier, might see a terrorist attack as a psychic reorganizer, an opportunity for positive changes. Others will be unable to achieve accommodation or assimilation, although most people are believed to go through a grief and recovery process after a terrorist attack.

Stage I: Disequilibrium—The Immediate Aftermath

During this first stage, when there is still uncertainty about the magnitude of the terrorist attack and potential loss of life and destruction of buildings, there is a sense of disequilibrium, which can lead to feeling terrified, helpless, and overwhelmed. Reactions might vary in seriousness based on the proximity and duration of the exposure to the terrorist attack, ranging from raw human emotions and ungoverned chaotic responses to numbness. For some, the reactions in the few weeks after the terrorist attack will include (a) verbally expressing anger, hurt, worry, and anxiety; (b) biological responses that perpetuate fear, which can lead to feeling overwhelmed and avoiding feelings, places, and people associated with the attack; (c) reexperiencing the event through nightmares and flashbacks; and (d) dealing with increased arousal, such as exaggerated startle response and hypervigilance. It is important to remember that people’s responses to personal factors, predisposing factors, peridisposing factors, postdisposing factors, and protective factors will vary greatly and impact their initial responses and reactions to terrorist attacks. During this stage, some people may struggle with social and occupational functioning, or they might be composed, controlling their emotions and providing factual information about the event, and confronting their vulnerabilities. They might
even deny having been impacted by the attack and will avoid dealing with their disorientation and report psychic numbness. This can be a temporary way to avoid a crisis reaction. Instead of focusing on their own needs immediately after the terrorist attack, these individuals might be preoccupied with the desire to help and engage in acts of kindness toward others, which can serve as a deterrent to their own emotions and reactions. The process of denial and numbing, which can vary greatly in duration, can serve as a protective mechanism for those for whom the terrorist attack was so traumatizing that it was overwhelming, as were the visual images and sensory (e.g., smell, sound, and tactile) memories. Others might experience a range of physical reactions based on how physically close they were to the event. They may have suffered minor injuries, life-threatening problems requiring little to no medical care, or trauma during minor treatment, surgery, or other invasive procedures. The presentation of somatic and physical illness, such as asthma and chronic pain, hypertension, heart palpitations, tremors, shortness of breath, might result in seeking out medical help. There might also be imminent threats of other attacks or bio-terrorism or the prospect of war. This could provoke fear of not being able to protect oneself and loved ones, especially children, and prompt a sense of a shortened future. Those with a previous trauma history might have a reoccurrence of PTSD symptoms.

For many people, the first few weeks after a terrorist attack are a time of high levels of emotional reactions and may involve sleep disturbances such as nightmares and night terrors. It is important to remember that media coverage and repeated visual images can be unbearable for some. Many people will also report struggling with short-term memory and difficulty with concentration. Some might avoid going to the site of the terrorist attack, whereas others will need to go to the site and have the desire to talk about it. Depressive symptoms include crying spells, sleep and eating disturbances, and feelings of hopelessness and disappointment. Suicidal ideation and suicide are often seen during this first stage of terrorism grief and recovery, especially when there is a history of previous loss and trauma. For other survivors, there can be survivor guilt, causing some to wonder why they are alive when others died or what they could have done to save others, especially loved ones, colleagues, and friends. Generally, during this first stage, people do not know what to make of the terrorist attack and what impact it has had on their personal beliefs and values. Most likely, all have been impacted, but there is still a sense of disbelief and unrealness.

Stage II: Denial—Outward Adjustment

During this stage, for many, the desire to assist others will quickly decrease as people are left to their own resources and remedies for dealing with the terrorist attack. Self-nurturance and support from family and friends seems to be an important remedy as people seek to return to their preterrorist attack mental health. During this stage, many seem to return quickly and impressively to their former, preterrorism level of behavior, but this does not mean that the person has not been impacted physically or psychologically. Some people achieve an outwardly appearing equilibrium by isolating themselves from the location (by dropping out of school/college, changing schools and/or jobs, or moving to other parts of the country) and avoiding social relationships (by having little or no contact) that they believe precipitated the interruption in this stage. Others appear to avoid acknowledging the dangerous vulnerability they have just experienced as a result of the terrorist attack. They might repress memories in order to avoid the heightened state of
physiological hyperarousal, which generally brings about insomnia, irritability, increased startle response, hypervigilance, and impaired concentration, generally induced by memories of the terrorist attack. For some, the unconscious efforts to shut down results in numbing as well as the development of dissociative symptoms generally associated with PTSD. They may also present with unexplained physical symptoms such as shortness of breath, tremor, nausea, stomach and other unexplained pain, as well as psychological effects such as diminished interest in activities and reduced ability to enjoy activities, sadness, anger and irritability, sleep disturbances, intrusive and repeated images, flashbacks, crying, disbelief, depression, fatigue, disorganization, anxiety, and despair. Others, however, especially those more removed in proximity to the terrorist attack or exposed only for a short duration, might ruminate about the terrorist attack, make speculations, and have hypotheses.

During this stage, people generally try to find a way to cope with the fear, helplessness, or horror experienced during the terrorist attack and the imminent threat of subsequent terrorism and war, developing ways to restore the outward appearing equilibrium. During this stage, coping skills are still limited and symptoms might be subdued as people try to cope through avoidance and isolation, appearing to have shown progressive improvement. Nonetheless, the psychological and biological responses and behaviors are impacted by personal factors, predisposing factors, peridispensing factors, postdispositional factors, and protective factors. Responses will vary greatly, as described previously, from limited responses that do not meet diagnostic criteria for PTSD, major depression, panic disorder, generalized anxiety disorder, or substance abuse. However, during this stage there is generally no significant improvement, and people have not really started the process of coming to terms with the terrorist attack and how it might have impacted their beliefs and values about the world, human nature, spirituality, and themselves.

Stage III: Integration—Coming to Terms

During this stage, the meaning of life is assessed on a personal basis, as well as what “really matters” and one’s priorities. There is a raised consciousness about the importance of family and relationships, and a lack of both or either is generally experienced as loss. There is a philosophical assessment by many of their personal beliefs and values, with the realization that they are dangerously vulnerable. It is a time when people need to come to terms with the terrorist attack, by (a) maintaining old values and beliefs, (b) deconstructing old beliefs and values (assimilation), or (c) drawing on old beliefs and values as they construct new ones (accommodation). These processes of assimilation and accommodation require cognitive and affective restructuring of previously held beliefs and values, a process that cannot start until there is a willingness to accept one’s vulnerability—that terrorism is a global crisis that can occur anywhere, at any time, to anybody. It requires that the person no longer experiences debilitating symptoms provoked by fear, helplessness, and horror in response to the terrorist attack, subsequent threats of terrorist attacks, bioterrorism, and war and that he or she will not spend energy suppressing thoughts, images, and memories of the terrorist attack that were overwhelming. The person no longer experiences survivor guilt from not having been able to avert injury or death of others or to have behaved differently during the attack than expected. This means that he or she has addressed the physiological, psychological, and behavioral responses related to the terrorist attack. For some, it also means having dealt with the loss of family members, friends, or colleagues that died in the terrorist attack and how it might have impacted their beliefs and values about the world, human nature, spirituality, and themselves.
attack. People in Stage III are typically able to (a) acknowledge that changes have occurred as a result of the terrorist attack; (b) acknowledge that their communities are vulnerable; (c) develop a subjective interpretation of the terrorist attack; and (d) restore or adjust their perceptions about the world, human nature, spirituality, and themselves. For some, this stage is interrupted and prolonged when media coverage continues to provide images of the terrorist attack. This is especially true with anniversaries of the attack, subsequent threats, bioterrorism threats, and the prospect of and actual engagement in war, which may interrupt this stage and provoke a recurrence of symptoms.

The time it takes to move through the terrorism grief and recovery model, as well as to what extent one might successfully move through all or some of the stages can vary greatly, based on personal factors, predisposing factors, peridisposing factors, postdisposing factors, and preventive factors, as well as the loss of a loved one or colleague. Additionally, van der Kolk and Fisler (1994) reported that “traumatized adults with childhood histories of severe neglect have a particularly poor long-term prognosis” (p. 185). Children, adolescents, and the elderly are believed to be more vulnerable to the psychological effects of terrorism as they are generally more dependent on others in accessing support services. Adolescents are especially vulnerable as developmentally they are going through a particularly stressful and confusing time (Brooks-Gunn, 1992). As terrorist attacks are new to the United States, it is difficult to predict how long it will take Americans to go through the terrorist recovery and grief process after the attack on the World Trade Center.

Increased difficulty in moving successfully through the terrorism grief and recovery process also holds true in situations of “financial hardship of the family, educational disability, and illness” (O’Halloran & Copeland, 2000, p. 106), as well as in situations of individuals suffering from neglect (Cohen, Berliner, & Mannarino, 2000), abuse (physical, sexual, and emotional), or biological or psychological challenges (depressive and anxiety disorders, attention deficit–hyperactivity disorder, conduct disorder, substance abuse, borderline personality traits) and poor-to-nonexisting support systems. Those who have lost a loved one or colleague and were injured (a double bereavement) might also deal with trauma grief and loss issues and prolong the terrorism grief and recovery process (Kubler-Ross, 1969).

In New York after 9/11, the repeated bomb threats on buildings around Ground Zero resulted in repeated evacuations, leaving many in a heightened state of fear and anxiety, preventing them from beginning the grieving and recovery process. Additionally, the anthrax threats, periodic threats of more terrorism on American soil, the war with Iraq, and more recently, targeted attacks on nonmilitary Americans in Iraq have prolonged the terrorist grief and recovery process for some. Finally, it is important to remember that the mass trauma resulting from the terrorist attack of the World Trade Center prolonged the terrorism grief and recovery process (and immobilized some) until they gradually gained reassurance about their own, and their family’s, safety.

Discussion

This terrorist grief and recovery process model is designed to provide insight for mental health professionals who work with people directly and indirectly affected by terrorist attacks. It is important for mental health professionals to know that the terrorist grief and recovery process might vary greatly after a terrorist attack based upon victims’ exposure to the terrorist attack, their experiences during the terrorist attack, whether they had to fear for their own...
and others’ physical integrity or life, and whether they were directly involved or observed the attack in person or on television. Individuals who have preexisting loss or grief issues or mental health issues might have a more difficult time dealing with the grief and recovery process; however, their exposure to the terrorist attack as well as family and other support are believed to be stronger predictors of successfully working through the grief and recovery process. The protective factors, which include stress buffers and resiliency, are believed to positively impact the grief and recovery process.

In considering this model, mental health professionals should take note of some of its limitations. The model is based on self-reports by New Yorkers, after a single terrorist attack—the attack on the World Trade Center. The sample was limited as it involved only New Yorkers. Americans in other parts of the country, further removed in proximity from the terrorist act, have not been interviewed, but this model will hopefully serve as a foundation for further research in the area of a terrorist grief and recovery. Finally, the model was developed after the terrorist attack on the World Trade Center and not on multiple terrorist attacks.

Conclusion

Thus far, there has not been a terrorist grief and recovery process model for a terrorist attack, which provides insight for mental health professionals regarding the different stages of the grief and recovery process. This model needs to be further assessed as to its application with other terrorist attacks. With the model presented, many questions still need to be answered, such as what time frame is involved in the grief and recovery process. Also, questions need to be raised as to what intervention and treatment strategies are most effective at each stage. How different is internal processing from external reality in affecting the grief and recovery process? For example, “If there really is a God, why did he not stop this from happening?” “I always thought that humans are basically good and decent.” “On 9/11 we saw the ultimate cruelty from one human being to another. Perhaps humans are basically evil.”

When considering the questions posed here, one should not forget the importance of education, that is, providing information about the terrorist attack that is factual and not sensationalized through carefully chosen sound bites and pictures. The impact of the media must be addressed in an attempt to educate consumers as well as the media. As the field of neurobiology is developing, it is important to incorporate that information into the model. The terrorist grief and recovery process model needs to be further assessed in order to help therapists gain a better understanding of the grief and recovery process and in turn help those affected by terrorist attacks to work through the different stages, as well as to gain an understanding that some of their reactions are normal reactions to an abnormal event. The model, with further research, can be expanded to be used after other terrorist attacks and, over time, can be broken down for different age groups.

References


