Crisis Intervention Responses to Children Victimized by Terrorism: Children Are Not Little Adults

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This article presents a brief overview of the effects that the threat of terrorism can have on children. To address this fear from a clinical perspective Roberts' (1991, 2005) Seven-Stage Model of crisis intervention is utilized as one very practical method to tackle the growing fears of the American public. Suggestions are provided for parents to assist the child in dealing with terrorism incidents. Too often the notion that adult treatment strategies can be applied to children can obstruct the effectiveness of treatment efforts directed toward children and young adolescents. Application of Roberts' model is stressed as an educational strategy used to help these young 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 6:22–35 (2006)]

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Since September 11, 2001, virtually every child in the United States has been vicariously exposed to terrorist incidents and scenes of war and war crimes through exposure to the mainstream media. A significant subgroup of children has been victimized directly through losing loved ones. In addition, the ascendance of a “war” culture where foreign military action is a routine component of U.S. government policy means that a significant portion of U.S. children from military families now live with the fear, uncertainty, and constant threat of violence imposed by having parents on active duty in hostile environments far from home. As helping professionals and parents it is incumbent upon us to prepare our children by developing adequate planning, assessment, and intervention skills to help children and families cope with an increasingly violent and uncertain world. At the same time, it is crucial that we do not unnecessarily or unintentionally promote excessive levels of fear and hypervigilance in children. This is perhaps a “fine line” to walk but one that can be achieved by understanding the specific developmental phases of childhood and psychosocial

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risk and resilience factors associated with post-traumatic stress in childhood.

No clear and consistent ways of avoiding terrorist acts exist. Many Americans feel vulnerable and trapped concerning the best way to avoid terrorist activity. Mental health professionals struggle with how to handle the fears that adult clients experience; yet, little is written in terms of how to best handle the fears of the young child. Children and young adolescents see and hear of these threats but cannot simply be told that “everything will be fine.” This article identifies the key developmental and psychosocial risk factors experienced by children and young adolescents that may affect their response to exposure to a terrorist incident and suggests strategies parents may employ to help children cope with the fear of terrorism.

**Terrorism and the United States**

Definitions of terrorism variously highlight methods, motives, and identities of perpetrators and differ across institutions and cultures. The U.S. Department of Defense defines terrorism 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” (Burgess, 2003). Terrorism targets innocent and unsuspecting victims with a purpose of heightening public anxiety. Although acts of terrorism may seem random, they are actually planned by the perpetrators whose main objective is to publicize their attacks.

Compared to natural and human-caused disasters, psychological reactions to terrorism are more intense and more prolonged (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 increase the magnitude and severity of psychological effects. First, terrorist attacks occur with a lack of warning, which 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. Areas that were previously believed to be safe suddenly become unsafe. Feelings of insecurity can be instilled in an individual for an extended period of time (Dziegielewski & Sumner, 2002).

Four elements of terrorist acts are associated with trauma: (a) the scope of destruction; (b) the exposure by citizens, survivors, and responders to gruesome situations; (c) the emotional anger caused by the intentional human causalities; and (d) exposure to a high degree of uncertainty, lack of control, and social disruption within society (Myers, 2001).

**Developmental Issues for Children**

In considering childhood reactions to terrorism, an understanding of basic cognitive and psychological development provides a basis for selecting developmentally appropriate crisis intervention techniques. In terms of cognitive development, language acquisition affects ability to process the events of a terrorist act. Prior to achieving the ability to use language to represent objects (4–7 years), children will not be able to express in words their reactions to a terrorist event. In middle childhood, increasing sophistication in the use of symbolic communication and greater skill in attending, planning, and decision making allow for greater reliance on language to soothe and comfort children affected by terrorism. By adolescence, the ability to reason about the future increases as does the capacity for empathy and abstract thought. As a result, adolescent reactions to terrorism may more closely resemble those of adults experiencing posttraumatic stress reactions.
As social beings, children learn to attach and trust others as part of their normal growth and development. In early childhood, strong secure attachments with parental figures will help children to cope with the trauma associated with terror. Oftentimes, children seek advice and parents are not sure how to best assist and influence their child’s decision making. When children are threatened or frightened, they can close up to those around them, retorting efforts to talk with “it is not your concern, and I am fine.” The parent then feels frustrated and is not sure exactly how to handle such comments. The child appears resistant; however, the child is still in need of the parent’s guidance and nurturing.

As children approach the age of 10 years, relationships outside the family increasingly grow in importance (Moody, 2001; Von Salisch, 2001). Peer groups and popularity play important roles in children’s lives, as do independent friendships. The goal in developing these peer relationships is to feel more accepted. According to Gifford-Smith and Brownell (2003), the more accepted the young adolescent feels the more accurately they are able to read cues within their environment. Although peer relationships take on increasing importance in adolescence, parents retain a critical role in promoting positive self-images and well-being for teenagers (Liddle & Schwartz, 2002; O’Koon, 1997). In coping with terrorism, parents of adolescents must learn to provide support for autonomy balanced with protection against excessive stress.

Traumatic Reactions in Childhood: Risk and Protective Factors

Children exposed to traumatic stress exhibit a variety of responses. In very young children, diagnosable posttraumatic stress reactions may be absent but more nonspecific anxiety reactions may be present. In middle childhood, children are more likely to reenact the traumatic event through play. By adolescence, reenactment of the traumatic event may continue. At this stage, impulsive or aggressive behaviors may coexist with traumatic reactions typical of adulthood (Hamblen, 2003a). At every age, significant psychosocial factors emerge as risk or protective factors promoting positive development or increasing the likelihood for poor outcomes in later life. Factors associated with increased likelihood of posttraumatic stress disorder (PTSD) in children are (a) being under 11 years of age and witnessing directly a traumatic event, (b) the severity of the event, (c) close physical proximity of the event to the child, (d) poor parental coping, and (e) cumulative exposure to multiple terror/war events. Children with adequate family support and with parents who demonstrate lower levels of distress in response to trauma are less likely to develop a PTSD reaction. More specifically, children identified as “at risk” due to exposure to parental homicide or sexual assault are demonstrated to be particularly vulnerable to PTSD. They warrant special attention in emergency preparedness planning efforts and postterror interventions (Hamblen, 2003a).

Understanding general features of risk and resilience in childhood helps to identify particularly vulnerable subgroups of children and youth. General categories of risk exposure known to exert negative influences on normal childhood development include (a) childhood maltreatment, (b) parental conflict, (c) psychiatric disorders in parents, (d) poor parenting skills, and (e) having a serious biomedical disease. Individual child characteristics known to promote positive outcomes in later life include (a) an easy temperament, (b) self-esteem and self-efficacy, and (c) intelligence. Social factors known to promote resilience in children are (a) the presence of a caring and supportive adult, (b) positive parent–child relationships, and (c) effective parenting skills (Kirby & Fraser, 1997).
Children previously exposed to individual, family, or social risk factors should be given special attention in response to terrorist acts. Intervention planners should make use of protective factors when applying crisis intervention methods. For example, Stage 4 of Roberts’ model involves helping the crisis victim deal with feelings and providing support. Efforts should focus directly on the role of parenting reactions in response to terrorism. Supporting empathically parents’ recounting of efforts to respond immediately to danger and plan for safety may make them receptive to additional parenting skills education once the crisis phase subsides. Similarly, helping parents cope with their own traumatic reactions can promote the ongoing presence of a functioning, caring, and supportive parental figure in the child’s life.

**Children’s Psychological Reactions to Terrorism**

Common feelings and reactions in the aftermath of a traumatic event include sadness, anger, rage, fear, numbness, stress, feeling 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 (American Psychiatric Association, 2000). When a child witnesses a disaster event, panic reactions in the form of agitation, rambling speech, trembling, erratic behavior, or becoming mute are possible. Signs of grief seen in disaster sites include fierce rage, crying, and immobile body postures (U.S. Department of Health and Human Services, 2004).

For young children, responses to victimization may differ from those of adults. Very young and elementary school children who do suffer negative consequences of exposure to terror may display regressive behaviors including reverting to bed-wetting or thumb sucking due to their greater difficulty in using language. Insecure attachments to parental figures are likely along with changes in behavior and mood. Play may include reenactments of the traumatic event. Other childhood symptoms more consistent with adult reactions include depressive symptoms such as somatic complaints, decreased interest in activities, appetite disturbances, and irritability. Clinicians and parents should be watchful for signs of suicidal ideation and high-risk behaviors such as alcohol and substance abuse among adolescents exposed to terror-induced trauma. Complicated bereavement reactions may be an additional psychological consequence for children victimized directly by terror. Loss of loved ones through violent means, particularly when witnessed directly by the child, initiates a chain of behavioral reactions associated with traumatic grief (Shaw, 2003).

Estimates of childhood posttraumatic stress symptoms vary considerably. Shaw (2003), for example, cites estimated PTSD prevalence in the range of 10–90% of children exposed to war- or terror-induced trauma. The unpredictable nature of terrorism affects children across the world differently. In Israel, for example, where frequent and random terrorist acts are commonplace, an estimated 30–50% of children exposed to a terror incident will develop diagnosable PTSD or another mental disorder (Gurvitch, Sitterle, Young, & Pfefferbaum, 2002). In contrast, only three of 22 elementary school children in the World Trade Center 1993 bombing developed diagnosable PTSD 9 months after the event (Koplewicz, 2002).

Indirect or vicarious exposure to terrorism is far too common for all children in this day and age. Television exposure to scenes of violence and bloodshed are pervasive and require that parents both monitor exposure to such televised events and process their meaning in developmentally appropriate ways. Although geographic proximity to a terror incident is
positively related to the severity of children’s maladaptive response, secondary exposure through the media may also elicit maladaptive coping strategies (Nader, Pynoos, Fairbanks, Al-Ajeel, & Al-Asfour, 1993). Webb (2004) has characterized these secondary exposures as “emotional” proximity. Having distant family members or acquaintances affected directly by acts of terrorism is an additional form of this secondary exposure that can result in traumatic grieving in children.

Helping Children Cope With the Psychological Consequences of Terror

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 needs to 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 PTSD (U.S. Department of Health and Human Services, 2004).

Applying Roberts’ Seven-Stage Crisis Intervention Model in Acute Posttraumatic Intervention With Children

According to Roberts (1990, 1991, 2000, 2005), a crisis by definition is short term and overwhelming. Terrorism involves a senseless disruption to an individual’s normal and stable state. In adults the usual methods of coping do not work. For children, the confusion is magnified. At a terror disaster scene, it is critical for the parent or responsible adult to remain calm and with the child. Moving a physically capable child to a secure quiet place is a priority and may require firm direction should the child be overwhelmed emotionally by being in the midst of a group of injured survivors or bodies. Verbal reassurance and brief physical contact (such as a hug) will help reinforce adult efforts to promote safety. Establishing this connection will allow the child to talk with someone who can be trusted, think, ponder, and, together with the assistance of the adult, regroup.

Reuniting parents and children separated as a result of a terror event should occur as soon as feasible. Parents separated from their children must be provided with their own support and reassurance to help them cope with the initial shock of the event. Clinicians should maintain a calm and safety conscious response to the situation as a method to model this behavioral response to an overwhelmed and emotionally distraught parent. Educate parents about strategies to communicate information about the event in developmentally appropriate ways to their children. Promoting the competence of the parent throughout the immediate crisis and resolution phases recognizes the primacy of the family unit as the primary resource to cope with the tragedy. Formal crisis intervention counseling techniques can begin once immediate safety is reasonably assured (National Institute of Mental Health, 2001).

Roberts’ (1991) seven-stage crisis intervention model 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 this 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.

When applying Roberts’ (1991, 2005) model, the same assumptions apply for children as for adults in that (a) intervention strategies follow a “here and now” orientation; (b) most interventions should be provided in a location as close to the actual crisis event as possible (Raphael & Dobson, 2001); (c) the intervention period will be both intensive and time limited, typically 6–12 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 (Roberts, 2000). The difference when applying this model to children is the supportive and valuable ingredient the parent or other supportive adult can play in the acknowledgment and adjustment phase.

**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. Other events that happen in the environment are more likely to be perceived as terrorist activity, regardless of actual cause. For young children that often see themselves at the center of all activity, this threat becomes even more pronounced. When the child feels alone and unprotected, it is difficult for the child survivor to progress past the active danger phase. Hazardous events or circumstances that can be linked to the recognition or reliving of traumatic terrorist events can include (a) growing public awareness of the prevalence of the traumatic event or similar traumatic events (i.e., 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 child respects that he/she has also been a victim; (c) victimization from a seemingly unrelated act of violence being targeted to the terrorist victim 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 child’s past (these can be highly specific to individuals and the trauma experienced). Thus, when dealing with trauma, sensitivity thresholds and the memories that serve as cues associated with the individual’s interpretation process can vary (Wilson, Friedman, & Lindy, 2001).

One of the immediate dangers in Stage 1 is the possibility of suicidal tendencies. Children can feel suicidal but often do not think about the permanence of the act. In addition to careful assessment of suicidal ideation, initial and subsequent hospitalization and/or medication may be required to help deal with serious episodes of anxiety and depression surrounding the event. In helping the child, be sure to assess the mental status of the helping or supporting parent or adult who may be helping the child. 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 children 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 in children, the questions to elicit...
signs and symptoms of suicidal ideation or intent should be direct in nature. The child should be asked about feelings of depression, anxiety, difficulties in eating or sleeping, psychological numbing, self-mutilation, flashbacks, panic attacks or paniclike feelings, as well as increased incidences of substance use. This subject should be approached slowly creating an atmosphere that the child feels safe and willing to open up the feelings that are being experienced. Because often these feelings are confusing, this should be acknowledged.

Once rapport has been established, the counselor needs to help the child concretely identify the degree of loss experienced and, based on the age and the circumstances of the trauma experienced, the individual’s living situation needs to be assessed. Helping the client identify members of his or her support system will help to assure that the client is out of danger, as well as remind the client of support that remains immediately accessible.

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 and to understand it as something beyond personal control. In addition, when dealing specifically with terrorism, the client must be made aware that other seemingly unrelated events might also trigger a similar paniclike response. Once aware that panic symptoms may reoccur, specific preparation needs to be made as to how to handle these occurrences and subsequent feelings. Because both child and parent are currently being subjected to periods of stress, which disturb the family sense of equilibrium, attempts to maintain or restore the homeostatic balance can be commonplace. Regression to earlier developmental phases is one example of a balancing response that some children might exhibit at this phase.

Recommended postterror event interventions differ according to the child’s age. Parents with very young children should be encouraged to reinforce daily living routines as much as possible, use brief discussions with their children, and provide appropriate toys (fire trucks, toy ambulances, etc.) to elicit play and focus on their own stress management through the practice of relaxation techniques. From ages 2 through 6 years increasing verbal fluency requires parents and crisis counselors to listen carefully and support a child’s effort to tell the story of a terror event in brief exchanges. Lengthy discussions are not appropriate for children at this age, but parents should help the child use words to express the connection between strong feelings of apprehension and the terror event. Expressions of fear, nightmares, and sometimes disturbing behavioral reenactments of terror events may distress preschool and school age children and cause concern for parents at this phase of recovery. The crisis counselor should reframe these expressions for parents as efforts to acknowledge and understand the terror event. Parents should be taught to respect and honor the validity of the child’s fears and to provide nurturance through avoiding additional exposure to violence in the media and provision of comforting toys or soothing nightlights, music, and so on. Training parents to set limits with inappropriate behavior and to monitor the child’s ability to cope in home, school, and community contexts occurs in this phase as well.

Therapeutic conversations for teenagers in Stage 1 should make use of the adolescents’ increasing reliance on peers as a source of guidance. Clinicians and parents should incorporate reflections that compare and contrast the teenager’s response to the event with strategies selected by members of his or her peer group. Ongoing dialog with the family about the event is important as a tool to promote good self-esteem. Encouraging adolescents to reengage in normal peer group activities that allow expression of creativity and mastery of skills is
also recommended for the immediate postterror stage (Hamblen, 2003b).

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. This may happen, for example, if the child continues to display regressive or resistant behavior that frustrates the parent. Crisis counselors must help the client focus on the problem (i.e., the terror event that precipitated the crisis or the reason for the visit). Once the client realizes and acknowledges that the crisis or trauma has occurred, they enter into a vulnerable state and may be less able to function effectively (Roberts & Dziegielewski, 1995). In the initial Stage 1 meetings, the assessment of the client’s past and present coping behaviors is 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 or victimization from terror may leave the child and the adult 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).

**Stage 3: Identify the Major Problems**

Once the major problems relevant to the particular event are identified and addressed, the establishment of support mechanisms becomes essential. 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 Meetings 3 through 6, the crisis counselor assumes 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 is a focus of discussion. 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. Although the child’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 4–8 weeks or until some type of adaptive or maladaptive solution is found.

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

Symptoms the client experiences are to be viewed as functional and as a means of avoiding further abuse and pain. Even severe symptoms, such as dissociative reactions or distancing from the parenting role, should be viewed as a constructive method of removing oneself from a harmful situation and exploring alternative coping mechanisms. Reframing symptoms as coping techniques can be helpful. In this stage (Meetings 6–8), the parent and child begin to reintegrate, and gradually the family reaches a new state of equilibrium. Each particular terror-induced crisis situation is unique (i.e., method of violence, duration of event, opportunity for escape, etc.), and the crisis response will follow a different sequence of stages.

Once the crisis situation has been acknowledged, 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. Increased awareness helps the client face and experience contradicting emotions (i.e., 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). Expressions of sadness and grief regarding betrayal and lack of protection open the client to 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.

Adequate attention to resolving grief reactions during this stage requires the clinician to explore the unique circumstances of the losses experienced by parent and child. At this stage, searching for the deceased and significant anger at those involved in rescue attempts will give way to the variety of emotions associated with uncomplicated bereavement. For a family who has lost a parent, crisis counselors should facilitate mourning the loss while helping the family explore alternatives for continued functioning without the lost spouse. Special attention is needed for parents and children who have lost a loved one where the body was never recovered as these situations may pose a higher risk for complicated bereavement reactions.

**Stage 6: Formulating an Action Plan**

In the sixth stage, the crisis worker must be very active in helping the family 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 he or she is not at fault or to blame. The doubt and shame of what his or her role was and what part he or she played become clearer, and self-blame becomes less pronounced. The client begins to acknowledge that he or she did not have the power to help himself or herself or to change things related to the event. Often, however, these realizations are coupled with anger at the lack of control over what has happened. In regards to terrorism, thoughts of revenge or anger at specific groups or political entities may be verbalized, particularly by adolescents (Hamblen, 2003a). 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 reinte-
grate 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.

Stage 7: Follow-up Measures

Although 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. Often follow-up can be as simple as a phone call to discuss how things are pro-
gressing. 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 the treat-
ment and later at the end (Dziegielewski & Powers, 2005).

Finally, it is important to realize that when dealing with postterror reactions, the determina-
tion 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 fostering the development and emotional growth. Recommend-
ing an additional consultation at an anniversary date of the terror event may be a particularly helpful intervention for some families. If additional intervention is requested, referrals for group therapy with other survivors of sim-
ilar trauma, individual-growth-directed therapy, couples therapy that is to include a significant other, and/or family therapy should be considered.

Recommendations for Parents

Capable emotional support from a parental figure is most important for the successful resolution of a terrorism-induced crisis in a child. Parents who solicit and make use of social sup-
port and stress self-management techniques following their exposure to a terror event will be able to provide the consistent, nurturing relationship necessary to help a child recover.

Clinicians should help parents to realize the importance of providing and continuing to build trusting environments throughout the human growth and development cycle. From this perspective, parents are encouraged to listen to what a child has to say and not be too quick to judge their children or impose their own interpretations of events when children experience difficulty coping in the aftermath (Center for Social and Emotional Education, 2004). Children need to have successful life experiences, but they also need to make mistakes.
This allows the child to learn that the parent will listen to open discussion.

As the child struggles with adolescence and a shift in attention from parent to peer, parents should not simply give up even if their initial attempts to help the child process understanding of the terror event may be rejected and avoided. When the child does ask for the parent’s advice, it is recommended that the parent be honest with his or her child. It is also important to tell the child the lessons that the parent learned and how now the parent would have addressed the situation differently. Even though the child may deny listening, much of what is rejected is not forgotten.

**Recommendations for Practitioners**

Adolescence and pre-adolescence can be difficult for parents. In response to victimization from terrorism, adolescents may display a mix of reactions ranging from regression to earlier forms of functioning to withdrawal and isolation, or more extreme forms of acting out. Clinicians must work closely with parents in the resolution of a terror crisis to help them distinguish normal developmental processes from indications of severe reactions to the trauma. Helping parents understand the importance of peer relations for adolescents and pre-teens is a crucial part of crisis work in response to terrorism. Without efforts to engage teenagers in discussions about the incident, they may rely exclusively on their peers for interpretations of the event and their own emotional reactions to it. In the resolution of a crisis, counselors who deal with pre-teens between the ages of 10 and 13 years should ask teenagers the following questions and prepare to address these issues conjointly with parents and children.

Counselors should have children describe reactions among their friends. For instance, say to the child, “pick two or three friends and tell me about your friendship; what some things you do together and what makes them your friend?” Ask the child “what do your friends do or say about [the terror event]; how are they responding to it?” These questions help in determining how the young adolescent views friends and what is important to them. To enhance the development of trust, direct questions should be asked. For example, ask the young adolescent to describe what trust is so that the counselor has an idea of reference for the child’s descriptions. Asking how the child goes about gaining or giving trust within relationships could also be of benefit. The most important assessment question is clarifying with the young adolescent how he or she goes about making decisions and obtaining advice. Appropriate assessment questioning techniques for clinicians working with young teens are (a) asking direct questions, (b) requesting clarification, and (c) asking the child to describe potential scenarios and plans for seeking advice and assistance during a terror event.

**Future Directions: What Do We Need to Learn About Helping Children Cope With Terrorism?**

Crisis responses to recent terror events and ways to cope with the resulting trauma and stress are diverse. Levels of stress that survivors experience, the sources of stress, stress related to self-esteem and self-perception, stress and coping skills, and how to best handle stressful terror situations are just a few of the many issues that need further research. Understanding the differential effects of direct and indirect victimization of children and variations in their susceptibility to posttraumatic stress reactions based on ethnicity are additional important directions for further research on terrorism (Pfefferbaum et al., 2003).
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 (Scharoun & Dziegielewski, 2004). This increased attention has led 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; Monat & Lazarus, 1991; Spitzer, 2002; Wilson et al., 2001). Recent events have led some researchers to claim that coping with trauma and stress has become a sociocultural 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).

Whether directly exposed to terrorist activity or not, the fear of terrorism is likely to continue to affect parents and children for the foreseeable future. Short-term crisis interventions should focus on helping parents to help their children understand cognitively the events, express and understand their related emotions, experience a renewed sense of control over their future, and reinitiate usual family and community activities (Schonfeld, 2002).

References

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