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In the Aftermath of September 11: Group Interventions with Traumatized Children Revisited

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ABSTRACT

The terrorist attacks of September 11, 2001, affected thousands of children psychologically, necessitating the mobilization of multifaceted mental health interventions in an ecological context. This paper reviews the major role of large and small group modalities in this challenging effort, with many of them based on earlier group work with child-victims of trauma.

> Both the cause and the cure of trauma-related psychological disturbances depend fundamentally on the security of interpersonal attachments.
>
> *van der Volk, 1987, p. 166*

> The need to understand the nature and severity of the risk factors involved . . . and to further test and develop appropriate treatment and prevention measures are now high priorities.
>
> *Lewis, 2003, p. XIII.*

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INTRODUCTION

The horrific events of September 11, 2001, stand out as unique in our history in terms of the noxious effects on masses of adult Americans and especially on their children. Accordingly, parents, teachers, as well as human services professionals have been grappling with how to address the trauma to the youths in their care. The gravity of the situation in New York City alone has been underscored by a survey conducted by the city's Board of Education which revealed that, six months later, thousands of school children had been rendered generally anxious, with about 10 ½ percent being more seriously affected and experiencing chronic nightmares, fears of public places, and other mental health problems (Goodnough, 2002). Such findings were substantiated by our own consultation work with parents, teachers, and artists engaged in outreach work in schools (Goodman & Fahnestock, 2002), as well as with varied human services professionals. Poignantly, the subsequent unrelated Columbia spacecraft disaster, coupled with the repetitive Homeland Security Department's terrorist alerts, have exacerbated these problems. As might be expected, a number of studies have also revealed that certain categories of children were especially vulnerable to the development of stress symptomatology, among them those who were very young, female, lacking in social support, and/or having a history of earlier traumas and other psychiatric disorders (Galea, 2002; Stuber, 2002).

PSYCHIATRIC CLASSIFICATIONS OF CHILDREN'S TRAUMAS

While the Diagnostic and Statistical Manual of Mental Disorders of 1980 (Third Edition) was the first to coin Posttraumatic Stress Disorder (PTSD) as a separate diagnostic entity, it was not until 1987 that the Revised Edition (DSM III-R) recognized it as being also applicable to children and adolescents. The most recent diagnostic criteria for PTSD (DSM-IV, 1994) prescribe that "the person experienced, witnessed or was confronted with an event or

events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and that the person's response to the trauma "involved intense fear, helplessness or horror" (pp. 427–428). We found Terr's (1991) broader definition more clinician friendly. She viewed childhood trauma as the mental result of "one sudden external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations" (p. 11). Terr noted, furthermore, that children's traumas entailed the following four major characteristics: 1) strongly visualized or otherwise repeatedly perceived memories; 2) repetitive behaviors which symbolized the trauma; 3) trauma-specific fears; and 4) changed attitudes about people, about aspects of life, and about the future. Thus, tied up with children's well-known fantasy world can be "omens"—private, usually irrational explanations of why the traumatic event occurred. With them may go a sense of having been, in some way, responsible for the episode. (Such feelings are especially common in instances of parental death.) Terr (1991) further differentiated between *single incident traumatic events*, which result in re-experiencing, avoiding, and increased arousal, on the one hand, and *chronic or prolonged exposure to trauma* which gives rise to denial, numbing, dissociation, or rage, on the other.

CHILD DEVELOPMENTAL CONSIDERATIONS IN TRAUMA

While most adults are bound to display some untoward reactions to traumas such as the September 11 tragedy, for children the challenge is much greater. Unable to make sense of international events, inexperienced in coping with major anxieties, and looking for orientation and strength from their elders who may themselves be emotionally shaken, traumatized children may have the very foundation of their world rocked. Furthermore, trauma has a greater impact on children than on adults, because children are in the process of developing. Traumatic events can alter brain development and brain chemistry so that concentration and learning are affected (DeBellis, 1999). Intervention after trauma is thus par-

ticularly necessary with children, to prevent a developmental blocking that derails critical growth.

We have learned from World War II's London Blitz that, notwithstanding the real dangers of war, the physical presence of parents and their emotional stability are primary requirements for a child's capacity for resilience (Freud & Dann, 1951). Accordingly, after trauma, even brief separations—as well as the well-known, anxiety-laden bedtimes—call for special attention and patience from adults. When toddlers and preschoolers ask questions, they need verbal reassurances that their parents and their known social networks are there to protect them. For example, they may need to be told that while there are "bad guys" out there, our army and police are on constant guard. Such brief responses are in order because preschoolers, while dimly aware of threatening events, are not likely to understand them. Hearing adults talk about such happenings is bound to make young children feel insecure, adding to the frightening imagery provoked by television's displays of actual violence. The fears of preschoolers are reflected in their play, and often indicate growing worries that "something might happen to me and to those I love and need."

With elementary school-aged children and their difficulty in separating fantasy from reality, it is important to let them tell first—through their play, drawings, and questions—what they think about and fear, before intervening. In this connection, elementary school-aged children know and imagine more than adults previously thought. While lacking perspective, they nevertheless comprehend the existence of dangers and evil. They fear that what they have seen and heard happening to other people could happen to them. Thus, a ten-year-old girl made a poignant drawing of the burning World Trade Center towers, with a falling child yelling, "I don't want to die." Building on such youths' characteristic natural concerns with rules and issues of "right and wrong," they need adult help in differentiating between perpetrators and victims, between the guilty and the innocent (Koplewicz & Goodman, 2002).

LARGE AND SMALL GROUP INTERVENTIONS IN CHILD TRAUMAS

Prior to the September 11 catastrophe, children's mental health literature had covered multifaceted responses to natural disasters such as hurricanes or floods (Lonigan et al., 1991; Lystad, 1988), as well as human acts of violence, as exemplified by the Oklahoma City bombing and the Columbine High School attack. There were also writings on communal violence abroad in Ireland or Israel, as well as in Bosnia (Arroyo & Eth, 1985). These reports highlighted group interventions wherein schools, generally, began with large assemblies and classroom discussions, followed by small group and, where indicated, family and dyadic measures.

In this connection, the University of California Los Angeles Trauma Psychiatry Program had developed a comprehensive public mental health approach aimed at helping traumatized children and adolescents. Their model has already been applied after various disasters in the United States and elsewhere (Pynoos, Goenjian, & Steinberg, 1998). For schools, this California model entails the following three-tiered set of interventions: 1) psychoeducational skill-building and supportive activities for the whole student body, to be provided by school personnel and aimed at enhancing the understanding and handling of trauma exposure and loss; 2) grief-focused group treatment alone, or in tandem with individual contact, addressed to students who were found to be at special risk for persisting psychological distress; and 3) community-based professional therapy for severely disturbed youths with depression, with suicidal ideations or psychosis.

Wolmer, Laor, & Yazgan (2003) reported on a research-supported group intervention effort in schools following a devastating earthquake in Turkey. In the absence of school-based guidance people, the authors trained and supervised general classroom teachers to assume the role of group leaders with the traumatized students. The project's results were impressive, showing a reduction within four weeks of about 50% in the estimated rate of PTSD cases. Needless to say, for children who remained

symptomatic after the psychoeducational interventions, clinical therapy (individual, family, or group) was later instituted.

Following the September 11 tragedy in the United States most schools, and especially those adjacent to the New York City bombing site, initiated larger-scale "debriefings," followed by small, class-intervention groups with mental health professionals in charge. These schools had employed a similar approach in the past, when faced with sudden tragedies, such as destroyed buildings or the death of a teacher or of a student.

Crisis Intervention Groups

Crisis intervention groups need to be differentiated from planned support groups, which will be discussed later (Lomonaco, Scheidlinger, & Aronson, 2000). In crisis intervention groups, after brief introductions and minimal efforts to establish at least a degree of connectedness (i.e., a feeling of being at one with the shock and pain), group discussions are focused on the reality of the event (what actually happened), followed by the appropriate expressions of feelings of loss and mourning. While the number of sessions is geared to the expressed need, group interventions are usually concluded with some act of resolution via memorial ceremonies and other concrete or symbolic gestures. As might be expected, the door is left open for additional counseling, as needed.

Support Groups

Support groups have been a part of mental health practice for many years. They are designed to offer emotional support to children who are facing a common problem or handicap. In contrast to the necessarily ad hoc crisis intervention groups, they can be planned with greater care and offered for longer periods of time. They derive their special motivational power from the fact that they are homogeneous and contain a shared sense of "being in the same boat" with empathically linked "fellow sufferers."

Among such groups are groups for children of divorce, which are usually sponsored by clinics or schools. As suggested by Cantor (1977) and by Kalter, Pickar and Lesowitz (1984), they are geared to 1) normalize the sense of being a child of divorce, 2) clarify the confusing and stressful divorce issues, 3) provide a safe setting to express and deal with conflicted feelings, 4) develop appropriate coping strategies, and 5) share the children's concerns about their parents. In the course of their group work, these authors discerned the need for more group time to help the children deal with such additional stresses of post-divorce living as problems with parental visitations and those raised by the parents' new partners.

Groups for abused children are generally conducted in clinical settings. They are initiated to prevent the well-known, profound symptomatology and personality changes subsequent to children's being victimized by trusted adults. If left untreated, lifelong problems with trust, interpersonal relations, and sexual behavior have been observed. Mandell and Damon (1989) produced a workbook for the group treatment of sexually abused children. A concrete, step-by-step progression aims to help the victims identify and express their conflicted feelings. Fostering healthy social skills and ways of dealing with adults in the future are included. Kitchur and Bell (1989) reviewed the relevant literature and offered short-term group interventions structured around a weekly theme, whereas Gilbert (1988) used developmental play therapy groups for work with younger, sexually abused children. These sessions included educational content which covered the important issue of "good touch" versus "bad touch" by adults.

In play group therapy with children 4 to 8 years old, the traumatized young child can be helped to re-live and correct the pain and misperceptions from past experiences—all through the medium of play. Play constitutes the child's language for describing his subjective experience. It is the analogue of the patient-therapist communication with adults. In addition to the more obvious value of doll house, soldiers, doctor figures, or puppets, there are also meaningful self-disclosures afoot when a child reacts with feeling to

winning or losing a game, or to an emotionally charged story or film strip. In the hands of skilled therapists, play can serve as a channel for "working through" painful experiences.

In the realm of group work with older, traumatized children, Rice-Smith (1993) depicted a comprehensive intervention program for sexually abused youths, built around the following six, graduated phrases: 1) acknowledgement, 2) stabilization, 3) uncovering, 4) mastery, 5) integration, and 6) transformation. There is encouraging research support for the value of short-term group interventions with child victims of sexual abuse (Kitchur & Bell, 1989). In fact, given the unique opportunities offered by the group medium, such as universality, normative peer support, interpersonal feedback, reduced isolation, and enhanced self-esteem, group interventions have come to be viewed as the treatment of choice for these problems (Finkelhor, 1986; Knitte & Twana, 1980).

Children's Bereavement Groups

Not unlike the instances of parental divorce, there is convincing evidence for the noxious results of parental or close family member's death on children's functioning (Doka, 1995). As noted by Berlinsky and Biller (1982), such youths show increased chances for delinquency, dependent personality patterns, introversion, suicidal ideations, and undue preoccupation with issues of loss. Furthermore, clinicians report immediate reactive behaviors in bereaved children, such as anger, clinging coupled with separation anxiety, denial, and nightmares, as well as regression in toilet habits. While most of the literature has centered on the individual treatment of such children, increased interest in the use of the group modality for bereaved children, often in combination with individual contacts, has gradually emerged. The majority of the reported group intervention models share the following sequential framework: 1) getting acquainted, 2) building group cohesiveness based on the shared affliction, 3) each child's relationship to the deceased, 4) feelings about the funeral and other means of saying

"good-bye," 5) anticipated changes occasioned by the loss, and 6) looking to the future and termination of the group. Notwithstanding the above-listed commonalities, practitioners have adopted a variety of techniques designed to achieve these same purposes. Accordingly, Masterman and Reams (1988) reported on an 8-session program comprising a co-leader team and designed for bereaved preschoolers and for school-age children, respectively. The sessions for preschoolers were less structured and entailed a group with no more than five children, aged 3-6. Each child was invited to bring a favorite toy to the session and to introduce it to the group. This was followed by an interchange about the toys. There then ensued a 15-minute free play period with toy ambulances, figures of medical personnel, and a hearse. The workers distilled from this play relevant personal themes such as anger, fear, magical rescues, and feelings of powerlessness and guilt. In addition, the adults initiated stories and puppet plays aimed at eliciting additional topics. As mentioned earlier in the discussion of play therapy for younger children, the overall therapeutic aims evolved around a continuous search for diagnostic indicators regarding individual children's specific concerns and misperceptions, which still needed to be addressed. In the same program, the larger, 8-member groups for elementary school-age children used discussions rather than play as the basic medium for communication. Within the total number of eight sessions, each week had a pre-announced theme: 1) the group's purpose, rules, and "get acquainted" activities, 2) self-disclosures about the circumstances of the parent's or significant person's demise, 3) exploration of feelings, including the family's involvement in the last rites; 4) changes in the family and its network, occasioned by the death, 5) coping with the loss, i.e., denial, anger, wishes, religious beliefs, guilt, 6) concerns and plans for the future, 7) feelings about the group's termination and ideas for future supports, and 8) closing rituals and plans for "staying in touch." This model differs in some respects from others described in the literature by featuring fewer than the most common 12 sessions and in calling for homework assignments, family genograms, and letters to the deceased. Most

important, it utilized "Little Red School House" groupings (mixed ages), instead of the more popular practice of similar age groups. In one other program, there was stress on the children's bringing in relevant photographs and other memorabilia of the deceased to the meetings, on an active involvement by the surviving parent, and on the use of a box for anonymous questions from the more inhibited group members (Fleming & Balmer, 1991).

Groups for Children of Alcoholic Families

Groups for children of alcoholic families are a recent development as research has revealed that children of alcoholics are at high risk of becoming alcoholic themselves or of marrying an alcoholic. The children's groups offer a supportive environment in which to explore and share feelings related to the usual "family secret," as well as to learn how to trust and talk openly about the real issues. Providing information about alcoholism and repairing strained family relationships are major goals (Bingham & Barger, 1985; Hawley & Brown, 1981). The most comprehensive overview of group interventions for children of alcoholics has been provided by Dies & Burghardt (1991).

Groups for Medically-Ill Children

Coping and adapting to chronic or severe illnesses is especially trying for children and their caretakers. The supportive group process lends itself well to promoting a readier acceptance of the handicap and facilitating cooperation with the required medical procedures. Group methods have been used for a wide range of ailments, everything from kidney disease through diabetes to allergies (Dubo, 1951). Flanagan (1983) described a group approach for children with cancer. In contrast to such typical homogeneous groups, Williams & Backer (1983) outlined a short-term, structured heterogeneous group for children with a variety of chronic illnesses. The sessions included factual information about the different diseases coupled with discussions of feelings and reactions

to the medical establishment as well as to parents. Open-ended groups have also been developed on pediatric wards with stress on the expression of fears, the correction of anxieties and distortions, provision of factual information, and, above all, companionship and mutual support (Cofer & Nir, 1975; Woodruff, 1957).

Trauma Groups for Inner-City Youths

MacLennan (1998) stressed the special value of mourning groups for inner-city youths where there are so many unnecessary deaths from AIDS, from family, and within drug-related violence. A detailed process summary of such a bereavement group for inner-city youths was offered by Keyser, Seelaus, & Kahn (2000). Parson (1966) had earlier described a multifaceted therapy program for traumatized inner-city children, built around an Urban Violence Stress Syndrome with such dimensions as damaged sense of self and confused self-identities, severed attachment bonds, cognitive stress responses, emotional stress, as well as moral stress response and distortion of ethno-cultural values. A similar, but even more comprehensive prevention and intervention approach was developed by Murphy, Pynoos, & James (1997) in an elementary school, serving a disadvantaged city area, characterized by high rates of crime and violence. An interdisciplinary staff conducted multi-modal interventions which comprised successive individual and group treatment, with a concluding one-to-one mentoring phase. The 12-session group therapy component contained the following elements: 1) promoting a peer understanding of each group member's traumatic experiences, 2) increasing emotional regulation and flexibility, 3) fostering empathy and emotional responsiveness, 4) enhancing social skills, and 5) encouraging the use of self-helping behaviors. The active participation of parents and the local police highlighted the program's wide perspectives. In a similar effort, Nisiveccia and Lynn (1999) used activity groups in an elementary school to help deprived children who had witnessed family or street violence. They provided a detailed account of the content and process goals

for each of the twelve group sessions, including games as well as activities geared to these children's developmental levels.

THEORETICAL CONSIDERATIONS

When viewed from the perspective of an individual child victim, short-term therapeutic group interventions are designed to lead the traumatized group member toward appropriate coping resources, that is, to the steps and means which help modify his or her self-esteem by reducing or eliminating the detrimental effects of the trauma and by restoring the earlier ability to function in life. In contrast to longer-term reconstructive psychotherapy, which aims at personality reorganization with the challenging of defenses, the aim here is more circumscribed--the elimination of dysfunctional behavior.

As might be expected, given the varied theoretical orientations afoot in psychotherapy, generally, and in group therapy, specifically, children's trauma group workers tend to be guided by their respective conceptual preferences. However, cognitive-behavioral approaches, having yielded some initial research support, seem to dominate the literature. The focus here is on "here and now" cognitive processes (i.e., attributions, beliefs, problem-solving skills) which are believed to lead to therapeutic change (March, Amaya-Jackson, Murray, & Schulte, 1998). Psychodynamic therapies, in contrast, stress the importance of covert ideations and conflicts as being responsible for current feelings and symptoms. As noted elsewhere (Scheidlinger, 1995), most group therapists tend to adhere to a pluralistic-integrative orientation that appears to be suited to the complexity of individual and group-level manifestations.

GROUP THERAPIST QUALIFICATIONS, FUNCTIONS, AND COUNTERTRANSFERENCES

As elaborated by Rosenthal (1977), a trained child group worker understands the basic concepts of group formation and dynamics operative in all children's groups and couples this awareness with

a knowledge of the specific "therapeutic" factors in group interventions. The major group therapist functions applicable to trauma-focused groups include: an individual preparatory session, if possible, to allow for a final screening, for the correcting of misconceptions about the group experience, and to establish a beginning "therapeutic alliance"; developing group rules with a focus on the creation of a safe, accepting group "climate" (holding environment); empathic acceptance and caring for each child, coupled with a belief in the latter's potentiality for change; encouragement for the open expression of feelings and concerns regarding the experienced trauma; fostering a climate of tolerance and acceptance for variance in feelings and behaviors (i.e., discourage pressure toward conformity); controlling the tension and anxiety level in individual group members within acceptable limits; controlling group-level manifestations (i.e., bullying, scapegoating, monopolizing, instigating) in the interest of an optimum state of group morale; verbal interventions via simple observations, confrontations, and explanations; and the introduction of appropriate techniques, as indicated—role playing, picture-slides, readings, or puppets.

Countertransference trauma work has been defined by Ziegler & McEvoy (2000) as containing "all of the trauma therapists' responses to the client, to the client's story, and the client's behavior, as well as the concerns and unconscious defenses mobilized by the therapist to protect him from these reactions" (p. 117). Accordingly, in addition to the usual countertransference themes linked to all group work with children (Azima, 1986), there are those evoked by the subject of trauma, among them, overwhelming feelings of horror, disgust, and pity; denial and minimization; over-identification and rescue fantasies; extreme reactions toward perpetrators; and doubts about the therapist's ability to contain the massive impact of the noxious emotion. In the instance of post-September 11 traumatization, workers have found it especially difficult to depersonalize the feelings of having been victimized together with the traumatized children. With it goes the anxiety inherent in the general expectations of additional attacks.

Terrorism constitutes an extreme form of trauma. It impacts not only on its direct victims, but also on their human network--from family to community--coupled with an acute sense of personal vulnerability. Co-therapy can, understandably, serve here as a support system for the helpers. Furthermore, ongoing supervision is a virtual "must" in trauma-focused groups (Schamess, Streider, & Connors, 1997).

THE INVOLVEMENT OF PARENTS AND OF CARETAKERS

The very notion of child therapy entails a steady and in-depth involvement of the parents in this process. Parents of traumatized children should be helped to understand the nature of the child's dysfunction and their role in aiding the therapeutic regimen. With this goes their need for support in dealing with their own myriad of anxieties as well as with having a traumatized child (MacFarlane, 1987). They also must observe and report the children's behavior, which the helpers need for assessing the progress of their work. Parents are, accordingly, seen in individual counseling sessions as well as in groups. The latter run, at times, in tandem with the children's groups. There is an extensive literature on such work (Arnold, Rowe, & Tolbert, 1978).

A CONCEPTUAL AND CLINICAL RECAPITULATION

1. Security in interpersonal attachments, the absence of prior stressors, and early opportunities to "tell one's story" in a supportive context are primary protectors against noxious aftermaths of traumatic events in adults and in children.
2. Posttraumatic stress evoked from an acute traumatic event in children responds well to small group interventions which allow for affective bonds within which the shared sense of the trauma restores a feeling of community, coupled with the building of bridges toward a better future.
3. Longer-term or very severe traumatization (i.e., familial sexual abuse, witnessing a murder), often requires prior, in-depth individual contact, followed by group-level interventions.
4. Trauma-focused helping groups (i.e., crisis intervention and support groups) differ from classical group psychotherapy (Slavson &

Schiffer, 1975) insofar as, instead of aiming at personality reorganization (repair), they utilize the usually short-term program toward a reconstruction of the traumatic event with its attendant feelings and misconceptions, coupled with plans for future coping and adaptations (i.e., "I may never forget it–but do not need to dwell on it").

5. Trauma-related groups, generally, share the following elements: a) stabilizing the physical and psychological reactions to the trauma in a safe setting, b) exploring and validating the members' relevant perceptions and emotions (use of words, drawings, role-play, etc.), c) retrieving suppressed memories, d) understanding the relationship between the stressors and current behaviors, e) eliminating elements of self-blame, f) learning new ways of coping, and g) physical activities, including relaxation exercises and body work.
6. Longer-term support groups are required for children with chronic disabilities, with pathological grieving, as well as with deep-seated posttraumatic stress reactions. Such children may also benefit from heterogeneous psychotherapy groups and/or family therapy.
7. Group counselors for the treatment of child-trauma victims require general personality attributes attuned to working with children, coupled with special training for children's group work. They also need to be open to an understanding and mastery of inevitable countertransference reactions.
8. Preparatory individual sessions with prospective group members are very desirable and can serve as a final means of screening, of obtaining a child's "group history," for clarification of misperceptions about the planned group, for establishing an initial therapeutic alliance and, above all, for working through the usual resistance of traumatized children to the reopening of "painful wounds."

A GLIMPSE AT THE FUTURE

Given the fact that most of this article was necessarily derived from narrative accounts of clinical experiences and intuitions of mental health practitioners, the need for evidence-based ways of group intervention with traumatized children is urgent. Kazdin and Kendall (1998) have outlined the necessary steps toward this goal. Meanwhile, many experts believe that in the absence of additional attacks, most people–especially children affected by the September 11 disaster–will cope and eventually feel better. Between 10 and 25% of the children who have been impacted directly or have

presented prior risk factors (i.e., earlier traumas, physical or psychological disabilities) are likely to require professional help. In these cases, the available social supports of parents, extended family, teachers, and clergy, as well as professional small group interventions, are believed to be primary factors in helping children to reframe and to transform events constructively in the prevention and treatment of trauma.

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