

Running head: GROUP THERAPY CURRICULUM FOR 9/11 WORKERS

DEVELOPMENT AND PROPOSED EVALUATION OF AN INTEGRATED GROUP THERAPY CURRICULUM FOR
9/11 RESCUE AND RECOVERY WORKERS

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Abstract

This dissertation introduces a time-limited group therapy treatment designed specifically for 9/11 rescue and recovery workers currently enrolled in the World Trade Center Health Program. A comprehensive review of relevant literature highlights the complex psychosocial and medical difficulties experienced by this population as well as the current lack of manualized and empirically validated treatments for 9/11 rescue and recovery workers. The proposed group therapy curriculum incorporates elements of various psychoeducation, support, and interpersonal process group models to be offered as an adjunct to individual treatment. The group curriculum is accompanied by guidelines for group facilitators regarding specific interventions and planning strategies, as well as techniques to foster group engagement and safety. Additionally, particular attention is given to certain logistical and administrative considerations related to implementing the group therapy curriculum as a research study within an established healthcare system. Planned evaluation of the group curriculum is proposed through an experimental design that seeks to examine the group curriculum's efficacy in reducing symptoms of distress using three separate outcome measures. Relevant statistical analyses are discussed, and potential strengths and weaknesses of the quantitative experimental design are reviewed. In addition, qualitative data-gathering methods are proposed via post-intervention exit interviews in a mixed methods research design. This dissertation aims to advance ongoing efforts to disseminate more theoretically integrated and evidence-based trauma-focused treatments that address the unique needs of rescue and recovery workers.

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List of Tables

Table 1: Summary Overview of Session Format, Titles, and Themes	16
Table 2: Visual Summary of Experimental Design Variables	107
Table 3: Summary of Yalom's Therapeutic Factors	116

TABLE OF CONTENTS

ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES.....	iv
CHAPTER I: Introduction	1
CHAPTER II: Review of the Literature	3
9/11 Rescue and Recovery Efforts.....	3
Impact of 9/11 on Rescue and Recovery Workers.....	4
Group Psychotherapy and Trauma.....	9
CHAPTER III: Methodology.....	13
Participants.....	13
Group Description.....	16
Outcome Measures.....	18
CHAPTER IV: People, Places, and Things: Preparing the Group	21
Mental Healthcare within the WTC Health Program	22
Recruiting Group Members	24
Group Intakes and Explaining the Group	33
Cultivating Group Commitment	37
Logistics of Group Facilitation	39
CHAPTER V: Implementation of the Group Curriculum	42
Session 1: Orientation to the Group.....	43
Session 2: Understanding Stress and Trauma.....	53
Session 3: Effects of Traumatic Stress I.....	60
Session 4: Effects of Traumatic Stress II.....	66

Session 5: Creating Individual Context for 9/11.....	72
Session 6: Understanding 9/11 as a Private Life-Changing Event	78
Session 7: Understanding 9/11 as a Shared Event	84
Session 8: Identity and the Self after 9/11	89
Session 9: Termination I.....	94
Session 10: Termination II.....	96
Special Issues for Group Facilitators	99
CHAPTER VI: Evaluation of the Group Curriculum.....	106
Quantitative Analysis of Group Curriculum.....	106
Qualitative Analysis of Group Curriculum.....	113
CHAPTER VII: Discussion	117
APPENDICES	120
REFERENCES	142

Chapter I: Introduction

For many American adults alive at the time of this writing, it is unlikely that there is not at least some familiarity with the events of September 11th, 2001. Even if that familiarity exists only in the abstract and takes the form of memories of television images, interrupted school or work schedules, or just the realization that *something had happened*, the 9/11 attacks affected the social consciousness of Americans in a way that continues to influence individual views of liberty, politics, and security today.

For some, particularly the individuals for whom this work is intended, the events of 9/11 are not merely familiar or remembered but are re-lived daily. In various and often incalculable ways, 9/11 is a day that has yet to end for the people who were most directly affected by it. For these individuals, many of whom are enrolled in the World Trade Center Health Program and the treatment services offered at its various Clinical Centers of Excellence, the events of 9/11 are far from forgotten, and are at times seemingly inescapable. While the acute danger of 9/11 has ended, the attacks that began on September 11th, 2001 have continued. What began as a direct assault on human life has continued, albeit through more insidious and clandestine means, as an assault on the autonomy, health, relationships, and identities of many. It is in response to these continued threats that this curriculum is offered, in the hope that the phrase “never forget” may serve as a memorial, and not as an epitaph.

As is the case in the development of most treatments in healthcare, various interventions in mental health have been developed in response to the particular needs of individuals experiencing problematic or disruptive effects of their lived experience. Over fourteen years since the initial event, many people involved in the rescue and recovery work associated with the September 11th, 2001 attacks at the World Trade Center continue to experience distress as a

result of their involvement with the tragedy. In an effort to help address the mental health needs of rescue and recovery workers who had various roles in the aftermath of 9/11, this project seeks to observe current findings regarding the problems experienced by members of this population and to propose an intervention that can uniquely attend to them. While many trauma-related treatments address symptoms, experiences, and reactions that are consistent with difficulties faced by World Trade Center responders, no specific (individual or group) treatments for this population have been developed or tested. The proposed project seeks to create a guided curriculum that incorporates current knowledge to address the needs of a specialized population in a group format. As a part of this project, the group curriculum intervention will be subject to a theoretical empirical study through which effectiveness and feasibility can be measured and discussed.

Chapter II: Review of the Literature

9/11 Rescue and Recovery Efforts

Over 50,000 individuals were involved in the rescue, recovery, and clean-up efforts of the September 11th, 2001 attacks on the World Trade Center (CDC, 2013). During the hours, days, weeks, and months following the initial attacks, a wide variety of professionals and volunteers were pressed into service as rescue and recovery workers- many of whom who had no experience or professional training in disaster relief work (Herbert et al., 2006). While much of the United States and the world grappled with the consequences and implications of the attacks, a highly specialized population was quickly and unwittingly being created through their direct involvement with the necessary response to an unprecedented tragedy on American soil. As a city, a country, and members of the global community responded with broad messages of grief, horror, sympathy, and rage, thousands of people working at the World Trade Center site each began to own a traumatic segment of our national timeline for themselves. Many of these individuals and the banners they labored under became vessels for a country's feelings of grief, pride, resilience, and desperate need for hope. In the 14 years following the 9/11 attacks many of these individuals are still struggling to cope with the relentless pressure, intensity, and instability they experienced while "doing their part" for the WTC rescue and recovery effort- a period of their adult lives which in many cases is still impacting them with a variety of psychological, spiritual, social, and physical consequences.

This large population of professionals and volunteers was comprised of traditional first responders (police, fire, and emergency medical personnel) and non-traditional first responders who were needed as critical support staff in both the immediate moments following the collapse of the World Trade Center towers and the months-long process of excavating both the towers

and the surrounding buildings that followed. These “non-traditional” first responders included operating engineers, construction workers, iron workers, sanitation workers, and other volunteers that worked alongside police, fire, and medical personnel in order to meet the urgent and stressful demands of the rescue and recovery efforts. Both groups of first responders were exposed to hazardous working conditions and a host of potentially traumatic psychological stressors. During the rescue and recovery effort, many individuals were exposed to continual fear for their personal safety, injury and illness, working long hours with limited supervision and support, performing difficult work in chaotic conditions, the loss of colleagues and friends, and the discovering and handling of body parts including inhaling the odor of decomposing bodies and debris (Landrigan et al., 2004; Neria et al., 2006).

While the national focus on 9/11 has decreased over the last decade in the context of domestic and global events running their course, the long-term effects of terrorism and the trauma it inflicts are still present within many members of the first responder population today. With trauma’s ability to unmoor foundational truths about safety, justice, and identity, the current distress still experienced by some World Trade Center workers should continue to be respected, researched, and incorporated into the field of psychology’s response to 9/11, so as to better treat both this population and other traumatized groups in the future.

Impact of 9/11 on Rescue and Recovery Workers

Since the official period of clean up and recovery ended in May of 2002, many notable efforts have been made to measure the medical and psychological impact of the experience shared by thousands of rescue and recovery workers during their time at the World Trade Center site. Although many more studies have examined the broader impact of the events of 9/11 on different populations, there is a base of research that has focused specifically on rescue and

recovery personnel. Nearly 14 years after the initial attacks, much of the literature demonstrates that overall the WTC responder population is at considerably greater risk for psychiatric diagnoses as well as long-term health complications than members of the general population. (Brackbill, Hadler, Ekenga et al., 2009; Corrigan, McWilliams, Kelly et al., 2009; Stellman, Smith, Katz et al., 2009; Wisnivesky et al., 2011).

Many of these studies are targeted toward measuring posttraumatic stress disorder (PTSD) specifically, but most of the relevant studies that will be discussed observe that posttraumatic stress among rescue and recovery workers is typically accompanied by a host of social and psychological difficulties that may not be specifically measured or reported in their findings. A meta-analysis of much of this literature conducted by Neria, DiGrande, & Adams (2011) sought to identify correlates of PTSD in a variety of highly exposed populations (e.g. evacuees, local residents, children of schools in proximity to the WTC site, etc.) during the events and aftermath of 9/11. For the purpose of reviewing the empirical findings regarding psychological distress for this population, focus is given to studies that have examined the impact on rescue and recovery workers specifically.

Evans, Giosan, Patt, Spielman, & Difede (2006) performed a cross-sectional study of over 626 disaster relief workers approximately two years following the September 11th attacks. Using the standardized PCL (PTSD Symptom checklist) and CAPS (Clinician-Administered PTSD Scales) measures the authors estimated PTSD prevalence rates at 5.8% in their sample. Correlates to PTSD included anger, distress, and reduced social and occupational functioning following the experience of providing aid at the World Trade Center and surroundings.

A similar study of over 1,000 disaster relief workers by Jayasinghe, Giosan, Evans, Spielman, & Difede (2008) used the PCL and CAPS measures to estimate a PTSD prevalence

rate of 6.8% in this population 3 years following the events of 9/11. Similar to the findings of Evans et al. 2006, reported feelings of anger, depressed mood, and psychiatric distress (not specifically assessed or diagnosed) were correlated with PTSD symptoms.

In a cross-sectional study of data collected from over 10,000 rescue and recovery workers over the course of one to five years following 9/11, Stellman, Smith, Katz, Sharma, Charney, & Southwick (2009) analyzed PCL scores and estimated PTSD prevalence at a rate of 11.1%. The authors concluded that correlates to increased PTSD symptoms included impaired social functioning, loss of a colleague or friend in the attacks, disruptions of family, work and social life, as well as reported behavioral symptoms in workers' children.

In a much larger study, Perrin, DiGrande, Wheeler, Thorpe, Farfel, & Brackbill (2007) used the PCL responses from a sample of nearly 29,000 rescue and recovery workers during a period of 2-3 years following 9/11 and estimated an overall prevalence rate of approximately 12.4%. They also found higher rates of PTSD in construction, engineering, and sanitation workers specifically, as opposed to the more "traditional" (and experienced) professional first responders. For this group, comprised mainly of 4,500 construction and engineering workers, the PTSD prevalence rate was approximately 20% during the same period of 2 to 3 years following 9/11. The authors also found that PTSD severity was positively correlated with earlier time of arrival at the WTC site, as well as longer duration of time spent working at the site. In addition, PTSD symptom severity was also correlated with having to perform tasks not common to one's occupation as well as being an unaffiliated volunteer.

A 2009 study by Evans, Patt, Giosan, Spielman, & Difede examined a cross-sectional sample of 842 utility workers who were involved in the recovery and clean-up efforts at the WTC site. The authors used the workers' CAPS responses from 17 to 27 months following 9/11

and estimated an overall PTSD prevalence of 5.9%. PTSD correlates again included impaired social and occupational functioning. Severity of PTSD among this sample also appeared related to individuals' reported history of depression and prior trauma.

A longitudinal study by Berninger, Webber, & Cohen et al. (2010) assessed PTSD symptoms in over 10,000 firefighters who responded to the WTC site over the course of four years following 9/11. Firefighters were assessed after one, two, three, and four years following their involvement with the WTC rescue and recovery. Over the course of their assessment, the authors estimated the PTSD prevalence rates to be 9.8%, 9.9%, 11.7%, and 10.6%, respectively. Similar to other studies that examined PTSD prevalence among 9/11 first responders, PTSD severity was significantly correlated with earliest time of arrival on site, prolonged work shifts at the site, and being forced into supervisory roles with little or no experience or training. In addition, PTSD prevalence was correlated with retirement due to a 9/11-related disability as well as impaired functioning both at home and work.

A 2011 study by Chiu, Niles, & Webber et al. examined a cross-section of 1,915 retired firefighters four to six years after 9/11. Among this population, the PTSD prevalence estimate based on PCL responses was 22%, and increased severity of PTSD symptoms were correlated to earlier arrival time at the site of the disaster. Finally, a 2011 cross-sectional study by Cukor, Wyka, & Jayasinghe et al. examined the PTSD symptoms in 2,960 utility workers nearly one to three years following 9/11. The authors estimated a PTSD prevalence rate of 8% for their sample, and noted correlates including subjective perception of threat to one's life and greater exposure to the site as related to increased PTSD symptoms.

In addition to the majority of research studies that have examined the prevalence of PTSD in this population, World Trade Center rescue and recovery workers have also been

studied since 2001 in relation to a host of health conditions and medical problems that are directly related to their time spent working at the WTC site. Upper and lower respiratory conditions such as rhinosinusitis and asthma are widely diagnosed within the responder population, along with other commonly observed medical problems such as gastro-esophageal reflux disease (GERD), obstructive sleep apnea, and increased risk of cancer and mortality from cardiac disease (Crane, Milek, Globina, Siefu, & Landrigan, 2011; Farfel, Digrande, Brackbill, et al., 2008). These studies have also reported high prevalence of other mental health conditions in addition to PTSD, such as: major depression, generalized anxiety disorder, panic disorder, and various stress reactions. While high prevalence as reported through various screening and assessment instruments do not represent confirmed diagnoses, the sheer breadth of problems and symptoms reported by WTC rescue and recovery workers suggests that they are a population in particular need for specialized care. While it holds true that many people who are traumatized by horrendous events do not seem to develop lasting effects, problems seen in the symptom clusters of PTSD alongside other problems including depression, increased aggression, depersonalization, dissociation, and decline in family and occupational functioning can occur without victims meeting criteria for “full-blown” PTSD (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

As longitudinal research continues to bear out, the complex interaction of physical and mental health conditions suffered amidst the backdrop of a national tragedy continues to afflict members of this population, and in many cases these difficulties have persisted with the passage of time. While the aforementioned research has focused primarily on PTSD, little research has examined other subclinical factors that affect quality of life. For example, feelings of betrayal, resentment, anger, and disgust may often color the experience of World Trade Rescue and

recovery workers who lack a forum to share or express these feelings, particularly as they are praised and thanked by those closest to them for their vital role following 9/11. Such dissonance and conflict regarding one's own experience may be one of the contributing factors leading to further isolation and lack of support. While most PTSD measures and the findings already discussed have focused on the symptom domains of individuals who have experienced a traumatic event, any sense of pride, duty, or appreciation for their role gets marginalized in an attempt to determine the burdensome costs of their experience. For some, these struggles are often compounded by the psychological toll of managing chronic pain as well as the uncertainty of ongoing medical conditions that frequently interfere with sleep and the ability to complete day-today activities with ease. As a result, many members of this group are facing or have already faced the prospect of forced early retirement, disability, or job loss due to these complicated factors that have arisen since their involvement with the World Trade Center disaster. In this sense, each loss or setback experienced by members from this group in a variety of domains can disrupt their ability to cope with their current stress, and interrupts any healing process related to their role in the rescue, recovery, and cleanup effort.

Group Psychotherapy and Trauma

Trauma is a ubiquitous concept within psychology and mental health. The concept of trauma, given its history and significance, has yielded multiple perspectives and definitions about what trauma entails- many of which may have their own merits and correlated ways observing, explaining, and potentially treating problems related to a traumatic experience. Trauma can be broadly defined as “the result of exposure to an inescapably stressful event that overwhelms a person's coping mechanisms” (van der Kolk, 1997). A traumatic event or incident could be characterized as a “situation-specific, severe and stressful violation or disruption that has serious

psychiatric consequences” (Klein & Schermer, 2000). The aforementioned consequences of trauma may result in “the disruption of physical, relational, and environmental autonomy and loss of safety and physical integrity.” (Yassen & Harvey, 1998). It is when these disruptions in a person’s sense of safety and autonomy continue to persist that treatment may be indicated and trauma sequelae enter the purview of mental health clinicians. The effects of trauma can result in a number of difficulties in the physical and emotional well-being of people who have suffered a traumatic experience. Effects of trauma can include social, relational, spiritual, and cognitive difficulties experienced months and years after a person has been removed from the traumatic experience itself. An individual’s trauma response is a complex interaction between their prior functioning in all of these areas, the nature of and exposure to the traumatic event, and the absence or presence of other environmental factors that impact an individual’s ability to cope.

In approaching treatment for individuals who have experienced trauma, an entire spectrum of diverse potential responses can be expected. When foundational aspects of existence such as safety and autonomy are threatened by trauma, the result is often not a tidy or easily classified pattern of symptoms. The interaction between the individual, their circumstances, and their trauma exposure affects many domains of functioning that can manifest as various disorders and sub-clinical difficulties that may elude broad diagnostic assessment. Because of the complexity and range of difficulties that befall those adversely affected by trauma, a “one-size fits all” treatment is unrealistic at best. However, given the shared cultural reference point that 9/11 has created, an opportunity for a shared experience during treatment can be created, just as the context (but not specifics) of the traumatic event have been shared.

In acknowledgment of this shared context, group interventions present themselves as a logical choice for treatment research and development. The special characteristics and

therapeutic factors that groups bring in general to psychotherapy treatment apply to the treatment of trauma as well (Foy et al., 2000; Kanas, 2005; Klein & Schermer, 2000). These therapeutic factors have been outlined explicitly by Irving Yalom (1970; Yalom & Leszcz, 2005). Many of the therapeutic factors map directly onto the kinds of difficulties experienced by trauma survivors. Specific therapeutic factors that are potentially relevant in addressing the trauma of 9/11 include (but are not limited to) the installation of hope, universality, imparting of information, altruism, development of socializing techniques, imitative behavior, and interpersonal learning. Because feelings of isolation, loss, and inertia are such pronounced effects of trauma, group therapy can facilitate a process of re-connection and interaction.

An optimal group therapy environment allows for interaction between group members in a uniquely structured milieu that seeks to cultivate and reinforce safety, autonomy, and trust. Because of this, group interventions are able to address areas in which trauma survivors have been the most affected (Klein & Schermer, 2000). For example, group treatment provides an opportunity for validation of a unique trauma experience, as well as an opportunity to witness and create a narrative about the trauma in a safe and respectful environment. Group treatments have been implemented by the Veterans' Administration for PTSD associated with combat, with one of the most common and effective treatments being Cognitive Processing Therapy or CPT (Resick, Monson, & Chard, 2006). Specific adaptations have been made to CPT to accommodate a group format. In such adaptations (CPT-G), group members work together to continually revisit and adapt a personal narrative of their traumatic experience while completing homework outside of groups in order to identify and evaluate areas that have become "stuck points" in their recollection of a traumatic experience.

While treatments like group CPT focus heavily on specific symptoms of PTSD, other group treatment models for trauma in general have emerged as well. Various types of groups have shown to benefit trauma populations in different ways. These types include supportive group therapy, psychodynamic group therapy, and cognitive-behavioral group therapy (Foy, Eriksson, & Trice, 2001). Supportive therapy groups attend to current life issues and coping while taking advantage of the group situation to reduce isolation and normalize an individual's response to trauma. Psychodynamic therapy groups consider the experience of the traumatic event and its meaning, and attempt to examine affective reactions as they relate to ideas about self and other. Psychodynamic group therapy can use interpersonal interactions to clarify the internalized model of relationships and feelings of weakness and strength evoked by the traumatic event. Cognitive behavioral therapy groups stress the development of coping skills to manage chronic symptoms, as well as an opportunity to challenge and reshape irrational or unhelpful thoughts and assumptions about relationships and the world. Groups targeted toward specific disorders like PTSD may use techniques such as exposure and cognitive restructuring to process group members' experiences of trauma and the impact of the emotional experience elicited by the trauma. Group approaches within each of these models have proved beneficial but far from conclusive, in part due to characteristically small sample sizes and a lack of planned comparison groups within clinical research designs (Schnurr, Friedman, Lavori, & Hsieh, 2001).

Chapter III: Methodology

The scope and purpose of the proposed study is to develop a group curriculum that draws from the literature regarding trauma, group psychotherapy, and the guidelines provided for working with first responders and World Trade Center rescue and recovery personnel. The proposed curriculum will adapt aspects of evidence-based treatments for trauma into an integrated, present-focused group format tailored specifically to the experience of WTC rescue and recovery workers. This curriculum will then be incorporated into a theoretical study designed to gauge the effectiveness of the intervention as compared to a treatment as usual (TAU) control group.

Participants

All participants will be drawn from individuals currently enrolled in the World Trade Center Health Program, a federally-funded treatment and research project that monitors that physical and mental health of program members involved in the rescue and recovery effort at the World Trade Center, the Pentagon, and the Shanksville, PA crash site. While this program also provides services for individual survivors who were in the New York City disaster area during the attacks, the participant pool will be drawn from individuals who served in a professional first responder or disaster services role or in a volunteer capacity anytime during the period of rescue and recovery that lasted from September 11, 2001 to May 2002. As a result, there will likely be considerable differences in the types of roles, amount of exposure to the disaster site, and the personal impact of involvement in the rescue and recovery effort among participants.

It is expected that initially these professional roles or organizational backgrounds (e.g. NYPD, FDNY, Port Authority) will form the basis for early sub-grouping within the larger group. This early fractionalization on the basis of affiliation or experience, should it occur, can

be interpreted as a members' concern about their own personal connection and status within the group. These issues should be considered "fair game" for the discussion part of the group intervention, although they may need to be raised by a co-facilitator as subgrouping in such a way may come naturally for group members. With the idea of subgrouping and affiliation on the table, the group may find new or unexpected ways of relating to other group members without having to refer to the structural oversight provided by a shared profession or role. For example, group members may begin to relate to one another on the basis of current difficulties in other domains such as health or relationships. While group heterogeneity may affect group interaction (particularly as group cohesion is in the early stages of forming), the same heterogeneity also allows for a place for the unaffiliated members within the group. The variety of roles, reactions, and experiences may provide additional "grist for the mill" during group discussions as well as surprising or otherwise unavailable opportunities for interpersonal learning and within-group feedback.

As members of the WTC Health program, individuals eligible for the study must also be certified for a mental health condition directly related to their experience of 9/11. This certification process is administrated by the WTC Health program and is completed through a process of assessment and documentation overseen by the Centers for Disease Control and Prevention (CDC). These conditions include, but are not limited to: major depressive disorder, dysthymia, generalized anxiety disorder, panic disorder (with or without agoraphobia), social anxiety disorder, posttraumatic stress disorder, anxiety disorder not otherwise specified, depressive disorder not otherwise specified, and specific phobias. Study participants remain eligible provided that they report current distress or difficulty in social, occupational, or physical functioning in addition to having a mental health certification. Distress or difficulty is assessed

based on the participant's self-report during intake. All potential participants will be screened for eligibility using a brief structured interview that clarifies the above criteria. This interview will be conducted by one of two group facilitators who will ultimately be conducting the ten group sessions together. This brief structured interview is conducted for eligible participants who are interested in the possibility of joining a group. Participation in the brief interview to determine group eligibility and interest will have no bearing on an individual's current treatment or status within the WTC health program. Participation in the brief structured interview will be entirely elective and only a requirement for program members interested in joining a group.

Patients who have met the aforementioned criteria and who complete the brief structured screening interview will be randomly assigned to either an experimental group intervention condition or a treatment as usual (TAU) control group. All participants in the group research study must also be currently receiving individual treatment (such as meeting with an individual therapist or psychologist or taking medication). Exclusionary criteria for the study include receiving another form of group therapy during the trial, an increase, decrease or cessation of concurrent (therapy or medication) treatment during the trial. Patients taking medication upon entering either the experimental or control condition should have been taking medication for at least one month prior to beginning in either condition. For individuals who are not placed into the experimental group condition, continued individual psychotherapy and/or medication management will constitute treatment as usual (TAU). While it is evident that medication management, individual psychotherapy, and the possible combination of these two treatments are not equivalent or interchangeable, an attempt to acknowledge this will be reflected in the proposed analysis of the group curriculum later in this paper. Given the inclusion criteria that have been outlined, it is not realistic to expect some individuals diagnosed with a certified mental

health condition to not be receiving some form of treatment prior to entering the study, nor is it ethical to ask patients to discontinue treatment in order to enter into the study.

Group Description

The group condition will meet for 10 consecutive weekly sessions, each session beginning with a brief psychoeducational component followed by a guided group discussion of a particular topic. Each group session will have a scheduled duration of one hour and forty minutes. The format and focus of each group session is outlined in Table 1 below.

Table 1

Summary Overview of Session Format, Titles, and Themes

	Session Title & Didactic Theme [Start - 20 min]	Topics for Group Discussion & Process [25 - 100 min]
Session 1	Orientation to Group	Introductions, 9/11 Roles, Group Norms
Session 2	Understanding Stress & Trauma	Relationship between stress and coping, causes of trauma
Session 3	Effects of Traumatic Stress I	Stress reactions on a spectrum, intrusiveness, avoidance
Session 4	Effects of Traumatic Stress II	Negative cognitions and mood, hypervigilance
Session 5	Creating Individual Context for 9/11	Pre-9/11 stress and coping, stress related to 9/11 role
Session 6	Understanding 9/11 as Private Event	Grief and loss post-9/11, Conflict around 9/11 legacy
Session 7	Understanding 9/11 as a Shared Event	Examining historical and mainstream perspectives of 9/11
Session 8	Identity and the Self after 9/11	Assumptive changes in view of world, self, and meaning
Session 9	Termination I*	Recognizing activation of group patterns around endings
Session 10	Termination II*	Clarification of group themes and relational development

*No didactic module or intermission break for this session

Groups should be approximately 6 to 9 members in size to provide necessary space to individual reactions and comments and to avoid a “classroom” feel for the psychoeducational component. Group membership should be closed following the first group session, as cohesion and stability are hypothesized to reduce distress and subjective experience of symptoms. Group psychoeducation and discussion should be facilitated by two co-leaders, as either one can be

made available as necessary to respond to a crisis reaction within an individual while another facilitator can remain with the group and facilitate processing of any situation that arises. For an individual who is experiencing acute distress or appears to be entering into a crisis state, they should meet privately with a facilitator in order to discuss their reaction. During such an instance, the individual facilitator's role will shift to assessing the current reaction to gauge any potential threat or danger to the group member or other individuals. After such an assessment is made, the facilitator should collaboratively plan a course of action for the patient and assist in re-establishing a sense of security and safety for the group member. Facilitators should inquire about useful resources available to the group member during past instances of crisis, and assist in increasing access to those people or resources. Because all group members are currently in individual treatment with a therapist, psychologist, or psychiatrist, the facilitator should obtain group member consent to contact their individual care provider in the event further assessment or planning is warranted.

Frequent acute stress reactions or crisis reactions from a group member may compromise the overall sense of safety within the group or may affect other group members' ability to tolerate their own reactions (however, this should not be assumed). In such cases, crisis management should also address the group member's desire and ability to continue participating in the group. An attitude of empathic concern and collaboration should prevail throughout, as no group member experiencing a crisis should be made to feel jettisoned from their group, but rather informed that more intensive, helpful, and appropriate care is available and would be of benefit to them. Although the proposed group model does not actively prompt group members to re-experience or recount their traumatic histories (as in Prolonged Exposure or Cognitive Processing Therapy groups), the possibility of adverse stress reactions exists for all members of

the group, and as such may affect group stability and cohesion if attendance or attrition become an issue that limits the productivity of the present group members.

Outcome Measures

In order to assess the effectiveness of the group intervention, all participants will complete a “pre” and “post” battery of self-report measures. These measures include the Trauma Symptom Checklist - 40 (TSC-40), the Posttraumatic Stress Disorder Checklist for DSM- IV (PCL), and the Outcome Questionnaire – 45 (OQ-45). The TSC-40 is a research measure that evaluates symptomatology in adults associated with childhood or adult traumatic experiences. It measures aspects of posttraumatic stress and other symptom clusters found in some traumatized individuals; however, the TSC-40 does not measure all of the criteria of PTSD. For a more specific assessment of PTSD in particular, participants will complete the PCL (PTSD Checklist for DSM-IV). The PCL is a 17-item self-report measure reflecting DSM-IV symptoms of PTSD. All World Trade Center Health Program members are familiar with filling out the PCL as part of their annual monitoring visits, and the common use of this measure in the established literature can provide one basis for comparison across other future studies. Although the PCL-5 is an updated version of the PCL that uses more current DSM-5 diagnostic criteria for PTSD, PCL (which uses DSM-IV-TR criteria) and PCL-5 items are scored with different ranges and thus are not comparable across studies or even to compare within participants’ previous PCL scores from prior years within the WTC Health Program. For a broader assessment of participants’ overall functioning and mental health outside of trauma-specific symptomology, the Outcome Questionnaire (OQ-45) will be used. The entire battery is estimated to be completed in approximately 30 minutes, and should be done at the time of a semi-structured interview completed with all participants in order to gauge eligibility for the study. At the conclusion of

ten weeks, both the experimental group condition and the TAU control group will be asked to complete the three-measure test battery again.

As previously mentioned, a structured qualitative interview will be completed with a group facilitator for every participant prior to their random assignment to the group intervention or control group. Each participant will be asked to participate in a similar exit interview, with group condition participants also prompted to reflect upon their group experience and to subjectively assess components or experiences that they found particularly helpful, or that they would wish to change, and why. This qualitative data will be examined and discussed in the context of Yalom's therapeutic factors, to see which factors may be most present within the group intervention as it is currently designed and implemented. Group facilitators will serve as administrators for all of the interviews in order to maintain continuity for members of both the control and treatment groups, but also for clinical reasons related to the program members who are ultimately assigned to the group treatment.

The potential to meet with a group facilitator for the pre-group interview is a way to initiate rapport-building between patient and therapist as well as to establish an early therapeutic alliance. This is done in an effort to reduce patient frustrations around being "passed around" a much larger system as well as to provide early clinical impressions for the group facilitators which can help to inform their repertoire of interventions once the time-limited group treatment begins. In addition, for individuals who are ultimately assigned to the control condition, the potential exists for these individuals to serve as a wait-list population for later groups or a second round of study and evaluation. In allowing for the possibility that the same pair of group facilitators may ultimately run multiple groups, engendering familiarity and rapport with members of the control condition is a useful way to cultivate a population for future group

referrals while also maintaining consistency across conditions by having the same facilitators conduct the pre-study interviews. Of course, the option to use independent clinicians who will not have a role in running therapy groups could help to control for some self-report bias and potential interviewer effects. However, choosing this method may challenge efforts to ensure consistency in how interviews are conducted during the (potentially lengthy) recruitment phase and could also be a possible barrier to therapeutic engagement later on. For example, if group-assigned participants are required to meet with unfamiliar facilitators after having met previously with different group interviewers, facilitators and patients alike may be at a disadvantage in attempts to establish rapport in a group setting as opposed to through the initial screening interviews.

Chapter IV: People, Places, and Things: Preparing the Group

The purpose of this chapter and the next is to provide a template for clinicians on how to create and facilitate an integrative, time-limited group treatment for members of the World Trade Center Health program. As previously discussed, group membership will be comprised of people who may be living with a variety of difficulties in relation to their experience of 9/11 and the recovery efforts that followed. To this end, much of this document is deliberately tailored to address the concerns of this specific population as they are assumed by the author given his own clinical experience with this population. In an effort to acknowledge that these concerns sometimes reflect assumptions from the author's treatment experience, the following is designed to be implemented as a guided curriculum and not an attempt at the more ubiquitous standardized treatment manual.

The concept of a "guided curriculum" is not introduced in an effort to be semantically fussy, but rather to genuinely reflect the author's hope that a treatment scaffold can be erected without imposing upon or restricting group facilitators' abilities to address the specific needs of their own unique groups. The sections that follow are meant to be presented in an accessible and succinct way that captures the themes and ideas that may be most relevant to the individuals for whom this group program is intended, and for the clinicians who can benefit from an organizing set of ideas from which to operate as they conduct their own group treatments.

Because the experiential product of every group is often the result of a unique matrix of individual personalities and their discreet and explicit interactions within the group itself, it is the belief of the author that a guided curriculum allows for an organic and flexible template for clinicians from which to develop their groups. As planning and implementing a standardized manual for a single individual's treatment can be difficult enough because of our limited ability

to account for divergent themes and material that arises during treatment, this curriculum will hopefully provide a realistic foundation upon which to base a more deliberately focused group treatment than would otherwise emerge in a traditional process group or unstructured support group.

This chapter will move the potential group facilitator through the process of planning, recruiting, and eventually running a time-limited integrated group treatment. Each discussion of these processes will include efforts to predict and help to address concerns, issues, or events that may arise during the course of any of these phases. Ideally, such discussions and efforts as they are presented here will provide facilitators using this curriculum a foundation upon which they can develop a rationale for how they wish to conduct their group with respect to their own group's developmental history and proposed trajectory.

Mental Healthcare within the World Trade Center Health Program

All group members will be members of the World Trade Center Health Program who are currently diagnosed with a certified mental health condition and are also participating in some form of individual outpatient treatment either by attending regularly scheduled therapy sessions or taking medication under the supervision of a psychiatrist at the time of group intake. In its current form, the World Trade Center Health Program and its various Clinical Centers of Excellence (CCEs) offer annual medical monitoring, intermittent on-site primary medical care for WTC-related health conditions, and various forms of on-site mental health care when feasible based on both clinicians' availability and patients' reported interest and need. That said, the WTC Health Program and its clinics operate together as an entity primarily devoted to physical medicine, with the majority of mental health treatment referred to off-site providers.

While routine medical monitoring occurs each year during an annual visit to a CCE, an individual's mental health is only comprehensively evaluated in a face-to-face meeting with a mental health clinician during their 2nd annual visit (referred to as the "V2" interview), unless the individual has reported distress upon their first visit or they are referred by a physician who believes that a patient may benefit from being seen by a mental health clinician. Outside of the second visit (V2) evaluation, there are few opportunities for individuals in the WTC Health Program to interface with the mental health care team unless they are referred by a doctor or nurse or they specifically request to meet with someone. While the physical medicine practice of the WTC Health Program focuses on early detection and proactive monitoring of common WTC-related health problems, routinely scheduled meetings with mental health clinicians do not occur outside of the V2 appointment, after an individual has already been enrolled for a year or more in the program. Because of this, recruitment for the group will require facilitators to take on a more active role in how they approach program members and share information about the group, as it is uncommon for mental health clinicians to interface with patients outside of the V2 interview or as part of a specific referral from another professional.

This particular aspect of how the WTC Health Program functions is highlighted to demonstrate one of the several potential barriers to engagement that program members may face. For individuals who may have been undiagnosed or untreated for years entering this new system, it may be very difficult to endorse distress or to suggest that their experience of 9/11 has continued to impact them outside of perhaps more demonstrable physical symptoms, many of which have been previously referenced. Conversely for individuals who have been enrolled in the WTC Health Program for some time, they may have become acclimated to the routine medical monitoring aspect of the program without any similarly routinized prompts to consider

or evaluate their emotional health and interpersonal or social needs. While several brief screening measures are mailed to recipients prior to their on-site annual visit, it is not uncommon for these forms to be left blank or for all symptoms related to depression or anxiety to be denied wholesale. Psychological issues more commonly endorsed are somatic complaints and health-related conditions which have had a more concrete impact on program members' ability to engage with their lives.

While improving the points of contact and efficacy of the few opportunities program members do have to discuss their psychosocial and emotional concerns within the WTC Health Program is outside the scope of this project, it is helpful for facilitators to keep in mind the environment in which they are attempting to start a group as they encounter resistance (both conscious and unconscious) from individuals and systems alike. The beginning of any new treatment requires energy, time, and effort, all of which can become quickly sapped in the face of patient ambivalence, logistical issues, and/or a lack of administrative support. However, such focused efforts to provide a new opportunity for those willing to participate can yield rewards not just for the group members but also for the facilitators and healthcare system as a whole.

Recruiting Group Members

When making efforts to contact, inform, and ultimately invite program members to participate in a group intake or join a group, facilitating clinicians will find themselves assuming the mixed roles of clinician, ambassador, and salesperson to various degrees and at varying intervals. Depending on a facilitator's comfort and experience, one's ability to assume these latter two roles will be particularly salient during the recruitment phase of group preparation. Successful group recruitment relies heavily on a facilitator's ability to help a potential group member understand the possible benefit of joining the group. As such, facilitators should take

the stance that in some ways the dynamics of their groups begin to form weeks or even months before the first session occurs.

It is likely that the most reliable source of new group members will come from individuals who are coming through the clinic in order to fulfill their annual medical monitoring. These individuals, simply through their participation in the medical monitoring aspect of the program, have demonstrated the ability to plan for and keep an appointment, tolerate paperwork and evaluation, and perhaps most importantly, they have remained involved in an activity that evokes and acknowledges the health impact of their role as it relates to 9/11. These are all characteristics that will also be required of group members. Previously enrolled applicants will have their certified mental health conditions, if they exist, on record in the database that is used across all four of the WTC Health Program clinics. This certification database lets clinicians know who among the patients currently visiting the clinic for their annual monitoring also carry a mental health diagnosis. As patients with mental health certifications complete their annual medical monitoring visits, they should be provided information about the group and an update regarding their current treatment (if any) should be made as part of their WTC Health Program chart.

While the annual monitoring visits provide a steady stream of potential group members through the clinic, it also means it could potentially take a year or more for all of the program members to attend their appointments at their home clinic. In order to gather potential referrals more quickly, group facilitators can also use the WTC certification database to contact program members by phone about the new group offering, and based on a patient's interest and eligibility, invite them to visit the clinic to arrange for a group intake appointment. Contacting program members by phone can require additional tact and planning as opposed to meeting with patients

who have already arrived in person for their medical monitoring visits. For example, program members are usually only contacted by the WTC health program for administrative reasons, and are usually not contacted by a clinician directly unless the patient has requested to speak with their doctor. It is important to understand the context in which these first calls are made, as it is an opportunity to present the group offering as a different kind of opportunity.

While program members may be accustomed to being contacted by an array of administrators or support staff concerning their treatment, benefits status, or future appointments, it is rare for patients that there is a great deal of continuity concerning contact personnel at the WTC Health Program. As a group facilitator, differentiating your role from that of other representatives of the WTC Health Program can help establish rapport and foster interest and participation in the group. A group facilitator making “cold calls” to program members for recruiting purposes and to gauge interest in the group can reassure and inform the potential group members they speak with that they will be one of two individuals conducting intake interviews and facilitating the groups. For group facilitators, making an effort to explicitly explain this will help patients know that they are not being solicited merely to see if there is interest in a new program but that there is a clinician who is responsible for being their point of contact throughout the rest of the process. An example for group facilitators about how this initial contact with a potential group member can be organized is provided as follows:

Facilitator: Hello [name of patient], my name is [name of facilitator]. I’m a clinician with the World Trade Center health program. I work at the [location and name of clinic] where you attend your annual monitoring exam.

Patient: Hi, hello. What’s this all about?

Facilitator: Well, I’m calling because we are starting a new program here at the clinic, and we are contacting people to see if they would be interested in participating. It’s a free group meeting with other 9/11 rescue and recovery workers. We’ve heard from some patients at our clinic that there aren’t a lot of opportunities for people in our program to meet with each other and talk about their experiences since 9/11.

Patient: Oh, like a support group or something? I don't think I need anything like that.

Facilitator: Well, the plan is to have some folks meet for a weekly group so they can talk about their experience of 9/11 but also to see how things have been going for them since 9/11. The group will only meet for ten sessions, and it's a chance for rescue and recovery workers to compare notes on how their treatment has gone since 9/11.

Patient: Hmm, I guess something like that might be different. I'm involved in a foundation and we do a cookout every year but there's not a lot of stuff during the year to talk to other guys. It depends on when the group starts, I got a lot of things going on right now. Would the group be with other (patient's specific role) like me?

Facilitator: The group will be made up of other people in the WTC health program like you, so there could be other (patient's specific role) but there could also be some (examples of other roles) in the group. The group will be a pretty comfortable size, somewhere between six and nine people. Myself and another clinician, (co-facilitator's name), will also be there to help things run smoothly.

Patient: Oh, so there might be some (role) there too? That could be interesting. I know the guys I was there with, but I don't know many (other roles).

Facilitator: Yeah, we're hoping we get a good mix of people so our patients can hear more about each other's perspectives but it's also to help some other members who may have had a tough time since 9/11.

Patient: Oh man, tell me about it. There's a lotta guys sick from being down there, but you don't hear much about it unless you were there. That's why I'm in the program, you know? I'm trying to get some of my buddies to sign up before it's too late.

Facilitator: Well, that's definitely something that we think would come up as a topic in the group. Like I said, there aren't many chances for rescue and recovery workers to talk about these things, so that's why we're starting this new group at the clinic, to see if it could be useful for patients. It would be great if we could meet in person to talk more about this. The other group organizer (co-facilitator's name) and I are scheduling appointments to meet with people who might be interested in the group.

Patient: Oh so you're meeting with people first?

Facilitator: Yeah, we would meet here at the clinic for about an hour. We can sit down together and I have a few short forms to fill out, but we can also talk about how the group might be helpful and I'll be able to answer any questions that come up while we talk.

Patient: Okay well I could probably do that. When would this whole group thing get started?

Facilitator: Well, since it's a new thing at the clinic, we want to make sure we have a solid group of people ready to go before we begin. So I'm calling other program members like you and we're trying to get people in to see how interested they are. I would stay in touch and let you know where we are with all the planning after you and I meet at the clinic. Since the group is new and part of the research that the clinic does, we may have different groups at different times, but we won't know for sure about a starting date until after (co-facilitator name) and I meet with everybody and we have a better idea of how many people we've got that are interested.

Patient: Alright, let me get my calendar.

In this role group facilitators serve as ambassadors of the group, but also serve as representatives of the healthcare system they are embedded in. Gaining a sense of a patient's familiarity with their own level of involvement with the WTC Health Program can be helpful, as it helps facilitators understand the patient's relationship and perceptions of the WTC Health Program as a whole. While there is no singular script to follow or way to predict how the offer of a new group will be met by program members, it is prudent to begin by providing background into the group and why it is being offered without conveying that the individual who is being contacted or invited for a group intake is being singularly selected on the basis of their WTC mental health certification. Regardless of whether or not a contacted program member is eligible or willing to complete a group intake or to participate in the group, facilitators should be mindful of their role as a representative of the WTC Health Program and their potential to make an impression concerning the group upon program members. A program member's availability or eligibility may change following the initial round of group recruitment, so there remains potential benefit in approaching interactions with all program members as potential opportunities to strengthen the group program overall, if not necessarily the group that is currently being recruited for specifically.

As important as these first contacts can be for the patients who are receiving their first phone call or who have been invited to spend part of their annual monitoring visit to meet with a group facilitator, it is also a critical developmental step in the group for the facilitators in addition to being a valuable source of clinical information. As contacts are made and program members reveal their interest in the offered group, the group development process begins. No longer existing only in the abstract, interactions between facilitators and program members are

the foundation for group members' relationships with the facilitators, and by extension, with the group itself.

Since the overall goals of the group include helping its members to acknowledge and address the difficulties their experience of 9/11 have caused them, very early in the group process facilitators can model flexibility, respect, and empathy by how they organize and attend to the group recruitment phase. It is important to provide follow-up as necessary for individuals who are pressed for time or request additional time to consider what the group has to offer. Many individuals may wish to discuss the idea of participating in a group with their primary mental healthcare provider, and will want to reserve the option of contacting you at a certain point. It is helpful to keep track of when potential group members have been contacted or have completed an intake, and that this information is shared between the facilitators. Maintaining consistent communication and providing updates to interested parties before the group starts or as the recruitment phase continues is both an act of courtesy on the facilitators' parts, but also demonstrates an acknowledgment that the group's success relies heavily on the facilitators and attendees working together in pursuit of a mutual goal.

Regular communication with group members who demonstrate early interest in the group and those who have completed group intakes while at the clinic can help to reduce anxiety about the idea of what the group will be, as well as to convey that the group facilitators are conscientious and similarly invested in the potential benefit that the group may offer. Through these efforts -which at times may feel tedious, unsuccessful, or decidedly "unclinical"- facilitators may be reminded of the daunting request they are making of individuals who may have been living with over a decade of ambivalence, avoidance, and physically and emotionally disruptive reactions to their associations of their 9/11 experience and its personal impact. While

difficult to do consistently or during every interaction (or unreturned call, missed intake appointment, etc.), facilitators should also acknowledge their own efforts to engage this population as a challenge worthy of their time, training, and expertise. An example of a simple follow-up call to provide an update to a previously recruited group member is provided below:

Facilitator: Hi (name of patient), this is (facilitator name) from the WTC clinic. We met about (length of time since interview) ago and talked about you possibly getting started with a group. I'm just calling to give you an update about where we are with everything.

Patient: Oh hey, (facilitator name) how's it going?

Facilitator: Fine thanks, (co-facilitator name) and I are calling the people we've been able to meet with so far to let them know that we're still in the process of meeting with other rescue and recovery workers, but that we're still planning on having a group.

Patient: Okay, thanks, I appreciate the call. I was wondering if I'd hear back from you guys, but I guess this kind of thing takes a while.

Facilitator: Right, like we talked about when we met- we want to get a good sense of everybody's goals so we can make sure that the group would be useful for everybody. But it does take some time to get everything organized so thanks for your patience.

Patient: Sure, no problem. I talked with Dr. (psychiatrist/psychotherapist) about it after we met and she thinks the group might be a good idea too.

Facilitator: That's great. Like I mentioned when we met, we're letting all of our WTC doctors and therapists know that we're starting a group here. Right now we don't know who will be in the first group that we're going to run, but thanks for filling out those surveys and for taking time to meet with me. It's a big help to us.

Patient: Yeah, happy to do my part. If any of the stuff you collect can help other people in the program, that's the important thing.

Facilitator: So we don't know who is going to be in the first group yet, but I will be getting in touch again to let you know what our plan is once we've finished meeting with everyone. For research purposes, everyone won't be able to join the first group because we have to limit the group size for it to be helpful.

Patient: Okay well, just let me know. Thanks for the update.

An integral part of the group recruitment phase also involves the relatively straightforward task of getting the word out about the group within the clinic and among the physicians, nurses, and administrative staff who interact with the program members. Enlisting as much help as is available to raise awareness about the group can elevate the group's profile among the clinic

in which it is offered as well as potentially create more points of contact and recruitment referrals from throughout the WTC Health Program. Because the majority of WTC Health program mental healthcare is referred to a network of outpatient providers, group facilitators should not stop solely at efforts to recruit patients directly through individual meetings and phone communication. As all group members will be in individual treatment, notifying the network of outpatient providers regarding the start of the group can serve as a potential source of future group referrals as well as to raise the awareness of providers around the group as a potential resource for their current WTC Health Program patients. If such contacts are successfully established, it should be emphasized that the group meetings are intended to be time-limited and adjunctive to the individual work already being provided by therapists and psychiatrists. For any group members or potential group members who may be undecided about participating in a current group or a future group offering, enlisting the informed support of their primary mental healthcare providers can help to reduce ambivalence and increase patient motivation toward participation in a group treatment.

Given the need for a control group that is inherent to determining potential efficacy of the group curriculum, the use of random assignment to experimental conditions necessitates that not everyone who is recruited for the group will ultimately be assigned to participate in the group intervention. The ability to deliver this information to both new group members and control group participants alike depends considerably on a group facilitator's capacity to be straightforward while maintaining a sense of empathy. Within this research design, participants are not blind to which condition they have been assigned, but retention of control group participants is critical to effectively evaluating the group curriculum overall. Because of this, group facilitators want to ensure that they remain responsive to control group members throughout the study so as

to preserve the integrity of both the experimental (therapy group) and control (individual treatment as usual) conditions. An example of how group facilitators can frame a program member's assignment to the control condition is provided here:

Facilitator: Hi (patient name), this is (facilitator name) from the WTC health program. I'm calling to give you another update about the group we are starting.

Patient: Okay, thanks for calling.

Facilitator: So we were able to find a pretty large group of program members who we think would do well in the group. Unfortunately, we have to keep the size of this first group limited to about eight people. We'd like to ask you to be part of our waiting list while we run this first group.

Patient: Alright well, no big deal. If you guys run another group you can call me up again.

Facilitator: Thanks very much for your patience throughout this whole process. Because the group is part of a research study, people who are on our waiting list can help us gather some information that will let us know if the group is helpful or if we need to make some changes if we were going to run another group.

Patient: Oh yeah, how's that?

Facilitator: Well, we are asking people on the waitlist to fill out the same set of forms that they completed during our first meeting. We would mail them to you with a return envelope. Basically, we just want to compare the two sets of forms for research purposes. All of your responses would be confidential just like your medical records here, and all the information from your forms would be anonymous for the research we are doing. We talked about this during our meeting, but I just wanted to check in and make sure it's still okay to mail you the set of short forms in 10-12 weeks.

Patient: Okay, no problem. I'll fill out whatever I get when you send it to me. Do you think you guys will be running another group?

Facilitator: We are hoping that if this round of the group goes well that we will be able to have more groups in the future. As you know this is the first time we've tried to have groups at the clinic so we want to make sure we're offering something that can be helpful to our patients. If we do offer more groups like this one, we would definitely start with people on the waiting list for this group.

Patient: Alright, fair enough. I'll keep an eye out for your forms.

Facilitator: Thank you (patient name). It may not seem like much, but sending back those forms will give us some information we can use to help make sure we're offering patients at the clinic the right kinds of help.

Finally, it is important for group facilitators to make sure that they are at all times being transparent and candid with program members. For example, if group facilitators are aware that

their site in question will not be offering a second group, or if the potential of a second group will depend largely upon the successful execution of a first round of the group curriculum, this should be conveyed to control group participants. In this scenario, the data and feedback provided by non-group participants remains just as important to the overall research design. Irrespective of the importance of random assignment to the research goals of this particular design, it is ideal clinical and ethical practice that the program members who both convey an initial interest in group treatment and then go on to complete a group intake with a clinician (but do not get assigned to the group condition) ultimately be offered a group therapy referral at some point following the conclusion of the research period (either internally or to an affiliated provider).

Group Intakes and Explaining the Group

For eligible program members who have agreed to participate in a group intake after demonstrating some interest in the group program, it is useful to consider an approach to the group intake process that can be both helpful to facilitators and group members alike as well as routinely implemented. The purpose of the group intake for this group is to get a sense of an individual's unique presenting concerns and to orient them to the structure and expectations of the group. Additionally, potential group members will complete several measures that will help establish a baseline assessment of symptoms endorsed upon intake, so that follow-up measurements can have a basis for comparison at the end of the group treatment.

An early task when discussing the group during the group intake is addressing with the group member how the group may be used by its members. Given the unique setting and nature of a group treatment, this determination can only hope to be made *in vivo*, when the eventual group members and facilitators begin to come together and interact within their own unique

milieu. However, for facilitators of a new group there can be some benefit in considering how group norms can start to develop prior to the first group meeting. The word “norms” used here refers to the implicit and explicit expectations for interaction and conduct as it affects the group. For example, one norm that is common among both group and individual psychotherapy is the expectation that a session will begin promptly at a designated time. Cultivation of such a norm relies heavily on the facilitators’ preparedness and consistency, but also the communication of such an expectation to the group. Many norms can be developed in response to concerns or events that emerge within the work of the group itself, but facilitators should be prepared to introduce the idea of norms and take an active role in helping to inform group members’ expectations about the group.

A more traditional interpersonal process group would see within-group norms negotiated and adopted as the group (ideally) progresses through the various stages of group development as outlined by Irvin Yalom in *The Theory and Practice of Group Psychotherapy*. While this group as it has been presented here seeks to incorporate aspects of group process into the curriculum, the time-limited nature of the group (ten sessions) and the brief psychoeducation and discussion modules at the start of most sessions (Sessions 2-8) mean that there is inherently more structure than in most typical interpersonal process groups. For group members, this is meant to provide an orienting sense of what the task of each group session may be, as well as to provide a topic or theme to guide the process component of the group.

The increased structure of this group compared to most interpersonal process groups also means that there are more opportunities for facilitators to be directive in guiding discussion while simultaneously attending (whether explicitly or not) to various aspects of group process. As facilitators, there is an opportunity to provide some structure and expectations even before the

first group begins, particularly during the recruitment and intake phases. Facilitators should be as direct and honest as possible in outlining the expectations and requirements of the group while simultaneously inviting group members to have their own concerns addressed and questions answered.

Participants in a group intake will be asked for a fair amount of personal and potentially emotionally provocative information, so a facilitator's ability to treat the intake as a clinical therapeutic situation and not just an exercise in data-gathering will more closely mirror the desired atmosphere of the eventual group therapy itself. By considering the questions that many people interested in joining the group will have, a facilitator will also begin to set their own expectations for how the group could be most useful to its members. In the process of addressing the practical and logistical questions that potential group members will have about the group itself, facilitators can learn to listen for the possible meanings behind such questions. The participation in a group of any sort can be a novel and anxiety-provoking process, and for a population that may have a variety of associations and reactions to group affiliation the task of joining a new group can be fraught with uncertainty and the potential for danger. With such uncertainty, however, comes also the potential for mutual understanding, a sense of belonging, and a more developed awareness of how the events of September 11th and its aftermath have continued to impact their lives and relationships.

During the group recruitment and intake interview phase, it is a fair and unavoidable occurrence for both potential group members to ask a variety of questions upon first consideration of joining a group- "Who is this group for?" "What happens in the group?" "How long does the group last?" are examples of questions that come up early in most group intake encounters. One aspect of psychotherapy that happens to be as much maligned as appreciated by

those who experience it is the attempt to answer one question which subsequently yields to the emergence of several other questions. The question of “Who is this group for?” is no different in this respect. For the potential group member, the question may be a coded version of “Is this a group I could belong to?” and should be treated as the first opportunity to establish a relationship and in some respect, to begin the therapeutic process itself. A question like “What happens in the group?” may speak simultaneously to an individual’s curiosity about the opportunity to participate in a shared experience with others as well as reflect a characteristic tendency toward the evaluation of a potentially threatening situation. The question of “How long does the group last?” may evoke both a desire to know logistically how the group might be incorporated into an individual’s day-to-day life, but could also speak to personal concerns about commitment, loyalty, and the ability to tolerate uncertainty. However, the meaning and significance behind these questions cannot be known with any objective certainty and certainly will vary among individuals.

Throughout the group intake phase, facilitators should practice being more comfortable in using their ability to listen empathically while gathering information as it is elicited from group members. This information can then start to form the basis for lightly-held hypotheses about individual presentations or conflicts and to help guide early conceptualizations of group members. Facilitators can complement these early impressions of group members with the knowledge that the one-on-one evaluation setting may evoke a different presentation from a potential group member than would be observed within a heterogeneous group scenario. An interviewer can use his or her impressions as a potential point of comparison when later seeing how this individual interacts with other group members. When answering program members’ questions about the group, it is helpful to recall that their ability to raise such questions is to

demonstrate a capacity to evaluate and make decisions, to convey thoughtfulness about what is and is not appropriate, and to examine where one stands in relation to other people. Each of these characteristics can be useful prognostic indicators toward a person's potential benefit from the group. Such questions are also indicative of the kind of curiosity and inquisitiveness that will help facilitate the start of a successful group, particularly one that will seek to integrate certain elements of psychoeducation and focused group process.

Cultivating Group Commitment

The concept of patient "buy-in" is a ubiquitous and pan-theoretical idea. Clinicians are all too aware that without a patient or client present and participating, efforts to provide treatment are limited if not impossible. The language of the phrase "buy-in" evokes economics, and suggests a transaction that occurs between patients and healthcare providers. In many clinical situations, this "buy-in" is reflected in a patient's willingness to pay a fee and dedicate a prescribed amount of time to address an issue they wish to have addressed. When it comes to the group as it has been proposed, "buy-in" refers to many of the same ideas, albeit with the caveat that the group program will be offered as an additional benefit of the WTC Health Program and thus will be offered at no cost to the group members. However, it may be unrealistic to expect that all patients will come to the first group having fully committed to participate or even attend all of the sessions. Facilitators should recognize that attending the group is in many ways an act of faith on behalf of those present, and an admission that there is a desire to see what the group may have to offer. One of a facilitator's primary goals throughout the planning and implementation of the group is to find and encourage opportunities to increase patients' commitment to the group.

Prior to the first group session, the co-facilitators begin by bearing the responsibility of group ownership, which they then seek to share with group members. Throughout the recruitment and intake phases of the group, the facilitators have hopefully demonstrated some of their own commitment to the group and its members, and have begun to model norms of respect, transparency, and accountability through their treatment of the recruitment and intake processes. While the facilitators are required to be custodians of the unoccupied, abstract group space in the early stages of recruitment, as the group moves toward its first session they will be asked to share ownership of the group space and encourage a mutual “buy-in” of sorts.

Commitment to the group as it is discussed here refers largely to one’s ability to attend the group sessions and loosely operate within the expectations and norms established first by the facilitators and, eventually, the group itself. Commitment should ideally move from something that is acquired “from” group members to a property that is shared “among” group members, such that one does not commit to participating or attending the group solely to see what benefit they can derive from the treatment, but because of the eventual recognition and belief that their presence is a vital aspect of what provides value for the group as a whole. Group facilitators begin the therapeutic process by believing that a successful group ultimately offers more than the sum of its parts. Cultivation of commitment among group members, perhaps in some ways a corollary to the group’s progression through the stages of group development, may not occur in a completely linear and apparent fashion. Because of this, facilitators should be mindful of potential opportunities to help draw attention to and support individual members’ attempts to demonstrate commitment to the group and their fellow members.

One such opportunity and subsequent intervention that can be employed by facilitators during the recruitment and intake phases prior to the first session is the reminder to potential

group members that the group itself will exist to serve the needs of all group members, not just the individual being interviewed for an intake. With this truth in mind, program members may decide to join the group while endorsing that their primary motivation is that they wish to provide support for other 9/11 rescue and recovery workers. During group intakes, such motivations should be taken at face value, interpreted as genuine, and encouraged. At the same time, facilitators may also begin to recognize an emergent defensive process taking place for group members who can readily endorse overt concern for others while simultaneously minimizing or disavowing their own need to be cared for. While such reactions are worth noting, particularly prior to the group beginning, facilitators can recognize this characteristic tendency toward helping others and support this motivation as a means of cultivating early commitment within the group.

Logistics of Group Implementation

Preparing to run the ten group sessions requires considerable administrative and organizational efforts prior to the first group. Part of the group recruitment and intake processes should be geared toward gauging both interest and availability of members to attend the group. This likely means developing a sense of when the group should be scheduled based on the schedules of members and the availability of a suitable physical space. Whenever making scheduling considerations, a utilitarian approach should be implemented. Once the facilitators have agreed upon a realistic set of options that they can both commit to, the group should be scheduled during a time that is most convenient for the greatest amount of group members, as it may not be possible for all potential group members to attend a particular time.

Securing a space that is regularly dedicated to the group is important in that the physical room in which the group occurs helps to establish a physical boundary that can be associated

with consistency and, ideally, with safety. The space should be comfortable and easily accessed by group members upon arrival, preferably with reasonable proximity to bathrooms if possible. Confidentiality is of paramount importance in helping to reinforce the safety of the space, so facilitators should make efforts to ensure privacy by notifying personnel in any surrounding offices or common areas that a group is in session in addition to taking reasonable measures to maintain confidentiality during groups (for example, through the use of white noise machines outside of the group room).

Facilitators should ensure adequate seating, provide tissues, and understand the evacuation procedures for the space in the event of a fire or other emergency. As outlined in the methodology and procedures chapter, facilitators should consider how they will navigate the space and the surrounding area in the event that a group member needs to leave the room due to becoming particularly activated or for another reason during a session. Facilitators should take steps to understand if coverage is available from a supervisor or other qualified individual if necessary, as well as to have a plan of how to notify emergency services or the police if necessary.

While it is difficult to plan ahead for every scenario, it may be useful for facilitators to consider how group members will flow into the clinic and then into the shared group space. Such considerations may include ensuring ample parking, signage about the group if necessary, and plans for how to retrieve or accommodate very early or very late arrivals to the group. It is helpful for facilitators to assume that first-time attendees may be anxious, uncertain, and ambivalent about the group- so any effort that reduces the logistical barriers to attending the group can operate in the service of reducing anxiety about the group itself. By planning out the practical details of all that is associated with running a group in a certain place at a certain time,

facilitators can reduce their own anxiety about issues that may arise as well as convey that what they are offering to group members is the result of deliberate and conscientious planning, which is a sentiment facilitators should hope group members can take into the beginning of their group experience overall.

Chapter V: Implementation of the Group Curriculum

Irving Yalom (2005) provides an apt description of time-limited group therapy in saying that all brief psychotherapy groups “strive for efficiency; they contract for a discrete set of goals and attempts to stay focused on goal attainment”. While time-limited groups may in fact strive for efficiency, the guided curriculum is an effort to ensure such efficiency. Facilitators will have the task of moving a heterogeneous group through a weekly exercise that integrates brief psychoeducational or conceptual topics followed by a period of unstructured group discussion and process. While any one component of this task would be difficult enough for facilitators to accomplish in ten weeks, facilitators implementing the group curriculum will have the advantage of seeing how the different aspects of the group structure will complement each other and ideally provide a new experience for those in attendance.

As Yalom (2005) notes, “A course of brief group therapy need not be viewed as the definitive treatment. Instead it could be considered an installment of treatment- an opportunity to do a piece of important, meaningful work...” In this spirit, the guided curriculum strives to be deliberate without being rigid, evocative without being overwhelming, helpful without being prescriptive, and a novel way to acknowledge how the past has influenced the present within the eventual safety of a group. Much depends on the facilitators’ ability to help navigate the group through ten sessions while monitoring and responding to the group’s collective “window of tolerance” (Siegel, 1999) wherein group members can be affectively engaged without experiencing the group itself as too threatening or as a potential environment for re-traumatization.

This chapter will introduce the curriculum topics that comprise the content of each session. Each session will be described with an outline of the “facilitator tasks” for both the

didactic module at the start of each session as well as the guided discussion and process component of the group that will follow. Additionally, this chapter will discuss the efforts and attempts of the group to move into a productive working phase. It is assumed that these implicit group “tasks” relate to emerging group dynamics that can be observed by the facilitators and will be considered for each session. However, because no two groups can progress through the guided curriculum in exactly the same way, especially when considering that all group dynamics will depend largely on the characterological composition and interpersonal styles of the individuals in the group, the session outlines are meant to provide structure while acknowledging the fluid and varied permutations of these dynamics. Particularly with regard to the discussion and process component of each session, any proposed observable dynamics that may emerge do so in an attempt create a more time-limited and directive simulacrum of the staged experience proposed by a more prototypical interpersonal process group.

Session 1: Orientation to the Group

Facilitator tasks of session 1 didactic module.

Introduction of facilitators, brief introduction of group members.

The first session is likely to be a time of anxiety and uncertainty for both the group members and group facilitators alike. However, some of this meaningful anxiety can be relieved by facilitators taking the lead and modeling how the first 20 minutes of groups are going to operate for the remaining sessions. Facilitators should begin by re-introducing themselves to the group, and also acknowledge that some group members may have not have been able to meet with both facilitators prior to the group starting. Facilitators should share a brief summary of how they are involved with the World Trade Center Health Program. To the extent that it is useful or relevant, facilitators should be prepared to discuss their training backgrounds or other

affiliations should group members inquire. Facilitators should encourage the group members to briefly introduce themselves (but facilitators can also expect that introductions among group members may occur spontaneously) and to explain that the first session will begin with an overview of how the group sessions will run in general. In the first session especially, facilitators should model transparency and honesty- addressing questions or comments from group members in a straight-forward and non-defensive manner. However, should questions move into a more personal arena or if a facilitator's subjective sense of what's appropriate or intrusive becomes compromised, facilitators can also model the establishment of respectful boundaries, such as by saying something to the effect of "I understand that it's totally natural to have questions or be more curious about _____, but for now our job is to focus on making sure the group gets started in a way that allows us to be more productive later on." Attempts at process interventions or questions about a group member's motivation for asking probing questions would likely be unhelpful at this point and may serve to heighten group members' anxiety. While specific personalities and roles within the group may begin to emerge quickly, the facilitators should direct the bulk of their efforts toward orienting the group and beginning to set the frame in which the group will work.

Explanation of group goals and purpose.

The didactic module of the first session consists largely of providing an orientation to the group and demonstration of the group format *in vivo*. The facilitators should emphasize that the group is a unique situation, perhaps different from other kinds of therapy experiences that the members have participated in before. Facilitators can begin to normalize the anxiety that typically accompanies a first group session by acknowledging that the unique scenario that is the group is typically accompanied by some uncertainty. Group members should be praised for

having demonstrated their commitment and patience throughout the group intake process, and reminded that the potential benefit of the group has already begun to coalesce, as it is represented by those in attendance. It should be noted that unlike the individual treatment that everyone in the group may be familiar with, group members are asked to recognize that their presence and engagement is an important part of the mutual support the group can offer. As everyone in the group has had a life experience related to their role in response to September 11th, the present members are in a position to recognize and validate other group members as well as to gain more personal insight into how their experience of 9/11 has affected their own lives. Each group is structured to address a particular aspect of these shared experiences and to elicit discussion. With that said, the facilitators should explicitly state that their job is to attempt to make the group a safe space to complete this work, and that at times they may feel the need to guide the group in a particular direction or make an observation about the group in order to help the group remain safe and productive.

Description of group norms, suggestions for potential norms.

After attempting to clarify their responsibility to maintaining an atmosphere that allows for the work of the group to flourish, facilitators should discuss the idea of “norms”. The concept of norms should be introduced as a set of agreed-upon expectations that include behaviors both inside and outside the group. It should be mentioned that group norms can be both explicit and implicit, but that typically some norms evolve as a group progresses. However, the responsibility of suggesting some common and important group norms to help structure the group in its nascent stage falls to the facilitators. In a way that connotes thoughtfulness and (at least some) expertise, the facilitators can introduce several norms that typically help groups to be successful. While more traditional open-ended groups would be afforded more time to shape

their norms and address concerns as they arise, because of the time-limited nature of the group facilitators are asked to address and attempt to pre-empt a number of behaviors that impact nearly all groups. Facilitators may struggle with not wanting to be overly directive or active, but by suggesting group norms in the first session facilitators demonstrate that they have a structure from which they believe the group should operate. In addition they can acknowledge that the early adoption of some important behavioral norms is born out of the reality that time is a valuable commodity that is better spent on material related to members' experiences of 9/11.

Confidentiality and its limits.

Although everyone in the group will have signed an informed consent around confidentiality, a discussion of the importance of confidentiality to the work of the group is necessary in the first session. Facilitators can point out that confidentiality applies not just to what they are permitted to share with other providers or individuals, but also what other group members agree to keep private and confidential about each other. An example may be introduced that differentiates sharing information about what is generally discussed in the group versus sharing a particular group member's story or experience. Facilitators should also review the limits of confidentiality from their perspective as clinicians, including their responsibilities in the event that they believe there is a potentially harmful situation for a group member or someone else. In many ways, confidentiality is the first assurance that group members are able to offer each other, so its adoption as a norm of the group is encouraged to promote safety and stability. Group members should be reminded that they will have an opportunity to discuss confidentiality and all of the suggested norms during the guided discussion portion of the group.

Punctuality and attendance.

Again, although group members have signed a consent form that explicitly states the expectation of attendance for the ten-week group therapy protocol, the issues of punctuality and attendance should be explicitly addressed by facilitators so there is clarity about how the group is expected to function. The expectation of attendance should be emphasized not solely for the purposes of the research project that the group members have agreed to participate in, but more importantly because regular attendance is in many ways a vital ingredient of what makes the group worthwhile. Facilitators should feel comfortable in expressing that groups are most effective when every member attends regularly, and that even one person's absence can strongly affect both the facilitators and the other group members. This aspect of the group should not be a new idea to those present, as it likely has been covered throughout the group intake process and was probably one of several key determining factors around an individual's eligibility for the group overall. The normative expectation of punctuality should be given in the context of establishing a culture of mutual respect, and that the time in each session has been carefully planned so as to take advantage of everyone's efforts to begin and end the group sessions on time. In presenting this expectation, facilitators can be firm but also acknowledge that external circumstances sometimes have an impact on members' ability to arrive on time. While facilitators are aware that persistent or repeated lateness may need to be addressed at some point, they should emphasize the importance of punctuality as a way of individuals respecting their own time as well as that of their fellow group members. This norm and its rationale should be introduced in a thoughtful and non-judgmental fashion, particularly if one or more individuals have already arrived late to the first session.

Cell phone use and side conversations.

In keeping with the theme of creating a culture of mutual respect, facilitators should encourage group members to refrain from cell phone use during both the didactic and discussion components of the group. While cell phones and tablets may have become ubiquitous accessories in nearly every circumstance of modern living, facilitators can point to the unique nature of the group and how it differs from other situations by suggesting the norm of limiting cell phone use to outside of the group time. This norm not only helps to increase engagement in what is being discussed in group but also to help ensure confidentiality during the group. Many people can relate to the common annoyance of feeling like someone is preoccupied during a conversation, and although the group setting is different from many dyads, it is assumed that participation in the group entails a willingness to attend to everyone's perspective. Because of this, facilitators can also ask that group members limit side conversations during the group, as they can be distracting or potentially hurtful to other group members.

Limiting out-of-group contact between group members.

While this norm is typically more common in open-ended interpersonal groups, it should be presented to the group members as a recommendation along with a specific rationale. Facilitators should convey that because the group develops and evolves through the formation of relationships and the mutual sharing of material during group time, interactions between group members outside of scheduled group time can alter the course of this process and potentially limit the effectiveness of other interactions within groups. Moreover, this norm is another measure to help ensure confidentiality about group sessions, as well as a way of reinforcing the significance and importance of group membership. Facilitators should explicitly request that should group members interact outside of the scheduled group time that they share it with the other group members during the discussion and process component of the group. Facilitators

again may feel uncomfortable asking group members to alter their behavior outside of the group, or feel as though they do not have a right to introduce this norm. However, facilitators can be sensitive to and understanding of the potential appeal that new relationships or friendships might hold for some members while also pointing out that these feelings are relevant to the group as a whole- and an opportunity for everyone to participate in the social learning that the group offers. Facilitators should conclude the didactic module by acknowledging that they have shared a fair amount of information with group members, and that the discussion portion of the group will afford everyone an opportunity to discuss what they make of the norms suggested and that together as a group they will decide which of these norms to adopt.

Introduction of brief break (3 to 5 minutes).

Following the conclusion of the facilitators' orientation to group, they should inform the group that every session will have a brief 5 minute break during which members can elect to use the bathroom, eat a snack, check their cell phones, etc. This break should be only several minutes long and is meant to differentiate the didactic module from the discussion and process portion of the group. While for the purposes of the first session the break may not seem or feel as necessary since the didactic module is comprised solely of orienting topics, it is an opportunity to acclimate group members to the structure and procedural flow of the following sessions. In addition, the existence of a break provides an opportunity for the facilitators to attend to any administrative or logistical tasks. Facilitators should encourage group members to make use of the break so that they can sustain their attention for the duration of the discussion and process portion of the group.

Facilitator tasks of session 1 group discussion and process.

Overall, group facilitators can expect to have a less active role in the group discussion and process portion of the group. In time, this portion of the group may be considered the most valuable aspect of the experience for the group members, as it allows them to engage with each other around the shared experience of 9/11 as well as other topics that are presented during subsequent groups. However, in the first session group facilitators should begin by asking the group for feedback about the norms that they proposed during the orientation. In many ways this is one of the few explicit and specific tasks of the group overall, and facilitators should assert that it is important that the norms of the group can be negotiated and adapted to meet the needs of this group of individuals. While there may be a tendency for group members to quickly accept the proposed norms without further discussion, the facilitators should invite group members to voice the agreement or their concerns explicitly so they can be discussed. This models an ownership stake in the group for each individual and also demonstrates a difference in the facilitator's role during the first part of the group, where they are introducing material without inviting feedback, to their shift to a participant-observer role during the group discussion and process component.

Particularly around the issue of confidentiality, achieving a group consensus is an important part of establishing safety within the group. At this point, individuals have not been asked to share any personal information beyond their names with other group members, so before the group can progress the facilitators should moderate and encourage the discussion or debate about norms that have been proposed. Once this task is complete, the facilitators should invite a more open-ended discussion in the remaining time. For example, facilitators can invite anyone who wishes to say more about him or herself and their role as it relates to 9/11 to use this

time as they and the rest of the group wishes. Facilitators may expect a range of reactions, however the group members will likely take turns sharing about how they were involved in the rescue and/or recovery effort, which may spark a flurry of questions and moments of connection or differentiation between members. Facilitators should feel comfortable sitting back and monitoring the group as much as possible while following the flow of conversation, and noting potential ways in which members to start to form initial impressions of each other. Facilitators should ensure that group members are notified when there is approximately ten to fifteen minutes remaining in the group time, and facilitators should be prompt in making sure the group ends at the appointed time. At the end of the first session, facilitators can remind everyone of the next session and thank them for their participation in the inaugural group.

While impossible to predict with specific certainty, group members will likely experience the first session with a sense of relief, perhaps even a sense of catharsis. After weeks or perhaps months of participating in the intake process and waiting for the start of the first group, members have likely vacillated between anxiety, hopefulness, and uncertainty in the time leading up to beginning the group. While it may be unlikely that group members are able or comfortable to candidly express this experience, there will likely be powerful moments in which people begin to share their stories with each other. It may become readily apparent that group members have varying levels of experience or comfort talking about their role in 9/11, and it can be expected that perhaps several members will provide little to no information about themselves at all but will rather choose to listen and follow along with what is being shared or discussed in front of them. Group members will inevitably demonstrate in some way how they attempt to seek membership or affiliation with others, and to the extent that facilitators can observe how

individuals go about this process they can begin to have a better understanding of the dynamics at work.

For each individual, there is no expected or desired level of participation in the first group, although at some point facilitators (who may be more mindful of the time than others) should feel comfortable making the observation that “not everyone in the group has been heard from”, as some members may feel as though they need permission or to be prompted in some way, whereas others may still decide they do not wish to share more about themselves.

Facilitators in the group should be comfortable establishing opportunities for individuals to participate without requiring or pressuring them to do so, particularly during the first session. Facilitators also have the responsibility to observe group members who may be moving outside their “window of tolerance” and provide opportunities for regulation or refocusing as necessary.

Facilitators may see multiple opportunities for connection between group members, and in that sense may have some insight as to the potentially overwhelming, intensely activating experience that is identifying themselves within the group and being the receivers of each other’s stories. Within the first session, a successful group is one that is able to address the normative concepts introduced in the first part of the group as well as to tolerate the lack of structure that follows in the group discussion and process component of the group. Of the therapeutic factors proposed by Yalom, the first session allows for the installation of hope, the imparting of information, and a sense of universality, hopefully planting the beginning seeds for a group that can become cohesive and mutually invested in by its members during the ten-week span of the guided curriculum.

Session 2: Understanding Stress and Trauma**Facilitator tasks of session 2 didactic module.*****Stress and coping as an expected part of human experience.***

While the first session's didactic module served the purpose of beginning to orient group members to the group situation and expectations, as well as to establish the format of a shorter, facilitator-driven start to group followed by a brief break succeeded by a group-focused discussion, the second session introduces the didactic module proper. In order to begin promoting continuity between sessions, facilitators should summarize the topics and norms discussed in the previous week. Following this brief review, facilitators can move on to the start of the content for this session's didactic content. To begin, facilitators can introduce the idea of stress and stressors as events and experiences that in some way elicit a response. These responses to stress can take a variety of forms, including physical, emotional, and behavioral responses. A good example would be to acknowledge that attending the first group session the week prior introduced a certain degree of stress to everyone present. It should be heavily emphasized that stress is a ubiquitous and necessary part of human life, but that particular responses to stress can sometimes result in more difficulty and greater levels of stress. It should be noted, however, that often without being aware of it we employ a variety of strategies that help us to tolerate the stress in our lives. The process by which we respond to stress is called coping, a term that is likely familiar to everyone. Coping implies that while we may never eliminate or defeat stress in our lives, an ideal coping response is one that helps us to adjust and react to stress with thoughts, behaviors, and feelings that can make a stressful situation or circumstance feel less dangerous or overwhelming.

Stress by itself is often given a negative connotation, and it is less commonly associated with its opportunistic potential for growth or reward. As an example, the facilitators can present an analogy to the stressful effect that a particular exercise has on a muscle in the body. The repeated use of a muscle to complete a task may in fact be very stressful, and experienced physically with discomfort, fatigue, and pain. However, with the employment of adaptive coping techniques over time the exposure of this muscle to routine stress will result in a healthier, more capable and more efficient muscle. When an athlete subjects themselves to the stress of physical training, they cope with a stressed, sore muscle by focusing on rest, nutrition, and flexibility. A lack of proper coping can result in a decline in performance or injury. Similarly, facilitators can point to the current group gathering as a stressful situation which people are presently coping with in an effort to experience a potential benefit. Facilitators may make the admission that all the factors that precede and surround attending a group (manipulation of life and work schedules, transportation, parking, disruption of personal and family routine, etc.) coupled with the knowledge that the group is designed to address their personal experience of 9/11 all serve to elicit stress. While being careful not to be patronizing in how they deliver this message, facilitators should point out that the ability of the gathered group to overcome the associated stressors of group attendance is a significant achievement in itself.

Introduction of trauma and its causes.

Much like the idea of stress, it should be expected that group members have their own understanding of trauma and traumatic events. In discussing trauma, facilitators should be very careful not to label the group members as traumatized, as they may have their own understanding or way of thinking about their experience that may not accommodate for the possibility or likelihood that they have been traumatized. Other members, however, may readily identify as

having experienced a traumatic event or events, particularly if they have been given a particular diagnosis or have been participating in trauma-informed or trauma-focused psychotherapy.

Facilitators can begin by offering the classic definition offered by van der Kolk (1987) that trauma is “the result of exposure to an inescapably stressful event that overwhelms a person’s coping mechanisms”. Facilitators can offer the idea that for some individuals their immediate experience or aftermath of the attacks on 9/11 may have been traumatizing, while for others some event or exposure to stressful circumstances related to or caused by 9/11 resulted in a traumatic experience. Facilitators can point out that this classic definition provides a useful semantic linkage between the ideas of stress, coping, and trauma, but that modern thinking around trauma has shifted somewhat to include a broader scope of experience that may result in trauma. For many, it is not one single event that is itself traumatic, but rather it may be a cumulative effect of stressful events over time, even if such events are not technically “inescapable”. Klein and Schemer (2000) offer the understanding that trauma is a “severe and stressful violation or disruption that has serious psychiatric consequences for the individual either soon or long after the event”. Advancing an even more inclusive and nuanced understanding of trauma, Fournier (2002) posits trauma as “a natural human response to the physical, psychological, social, and spiritual manifestations of stress in a person’s life”. All three of these definitions may apply in different ways to the members of the group, and should be offered as equally valid but ideologically distinct understandings of trauma. A broader working definition of trauma and its correlation to an individual’s ongoing subjective sense of risk and danger (as opposed to, for example, the objective criterion of “inescapable”) serves to understand the concept of trauma both as a potentially complex and diffuse set of experiences and also the more traditional understanding of a trauma as a specific overwhelming event.

Normalizing the relationship between stress and trauma.

In an effort to summarize the relationship between stress and trauma, facilitators can set up the discussion and process component of the group by reflecting that while stress is a common and expected part of our experience, trauma occurs when we are in some way made bereft of the ability to manage stress- such to the point that we feel endangered or overwhelmed. This can happen all at once, such as with the aforementioned training athlete's muscle which may suddenly tear and result in severe and definitive pain accompanied by a pronounced lack of functionality. Conversely, trauma may also occur over time and be slower to manifest itself, with repeated stress demands made on a dwindling supply of unreplenished coping reserves. Just as the muscle of the training athlete that is subject to a sudden calamitous injury can represent one form of trauma, so too does the muscle that has become overworked- susceptible to fatigue, deterioration, and injury as a result of chronic and unrelenting demands.

Finally, facilitators should end the introductory discourse on stress and trauma by affirming that just as there is no one definitive way that trauma can occur, there is also no one definitive way for an individual to respond to trauma and its effects. While those living with PTSD have by definition endorsed a certain number of symptoms across several different biopsychosocial clusters, individuals who have experienced trauma do not always go on to develop PTSD, but rather can respond anywhere within the spectrum of mental health. Facilitators should conclude to the group that the effect of a traumatic experience (including both acute and chronic experiences) is dependent on an interaction between an individuals' level of stress prior to the event(s), their prior trauma history, and the status of their coping mechanisms and resources at the time the trauma started. As a result of this interaction, we can see how responses to a particular traumatic event or series of events could look very different based on

the individual who experienced them. Just as they did at the end of the first session's didactic module, facilitators should explicitly state when it is a time for a brief break and they should designate a specific time for the group discussion and process to begin.

Facilitator tasks of Session 2 group discussion and process.

In Session 2, the group facilitators have a much less concrete task than was presented in Session 1. While Session 1 asked facilitators to guide the group toward a discussion around establishing norms, Session 2 asks facilitators to permit the group to consider the individual relationships with stress and trauma that each member has had. Facilitators should be particularly attuned to the group's response to the language used during the group, as the words "trauma" and "traumatized" can be particularly evocative for some members. Because the group is transdiagnostic in its approach to examining group members' individual experiences of 9/11, it should not be assumed that individuals have been oriented to the relationship between stress and trauma prior to the group. Therefore, it may become apparent that individuals have strong reactions to the idea of having been "traumatized", perhaps even sharing the common but inaccurate belief that trauma is an experience exclusively reserved for those who have been physically or sexually assaulted, or for soldiers who have been exposed to combat. Often these extreme examples may leave other traumatized individuals feeling like they may need to minimize the impact of their experience or to conclude that their experience "wasn't as bad as _____". The tendency to compare experiences among or between group members will likely occur, perhaps even if only privately. This may become more evident in the group if some members may openly assert that they don't feel entitled to or deserve a particular level of empathy or support, that they were "just doing their job" and that "it could have been worse". Such a statement can be interpreted as a reflection of the ongoing difficulty to validate the

traumatic or intensely stressful experience that resulted from 9/11, as well as the struggle to feel further validation as a member of the group, of someone hurt enough to deserve help.

Facilitators may understand that such a claim may serve a defensive purpose, both of denying one's own experience in a more primitive effort to cope, but also to maintain a particular role as someone who does not historically need or seek help. Facilitators should continue to notice this phenomenon as it occurs, but should also be mindful of the potential disorientation that drawing explicit attention to it could cause, particularly this early in the group. Process interpretations around defensive behaviors or statements may compromise the nascent safety of the group at this point, and likely will not be a major focus of the group's overall work due to the structure and time limits of the curriculum. However, facilitators should feel comfortable in stating the obvious (but perhaps unspoken) sentiment that it is difficult for the individuals in the room to acknowledge that their experience of 9/11 left them compromised in some way. If the group can tolerate and even engage with such a sentiment, facilitators could weigh the potential benefit of making further trial interpretations. Facilitators should seek to validate all reactions to the impact of stress and trauma that the group has, but they can also begin to consider ways in which the group engages in avoidance or struggles to discuss the impact of stress on their past and present functioning.

One way that facilitators can structure the discussion component of the group is to prompt the group to reflect on their own role in response to 9/11, and to consider which aspects of that role were stressful or traumatizing. It should not be assumed by the facilitators that all group members will draw a direct correlation between 9/11 and trauma, as for some the experience of repeated stressors linked to their 9/11 role is associated with a debilitating or traumatic experience. For example, group members who felt that they coped with 9/11 relatively

well but have since developed serious health problems as a result of their environmental exposure may now feel vulnerable in a very different way than a group member who experienced the sudden loss of several friends and colleagues on the day of the attacks. These differences speak to the magnitude and complexity of 9/11 as an event, but also begin to establish similarities and differences among group members. Just as there is no definitive or typical way for rescue and recovery workers to have been affected by 9/11, there is no definitive or typical experience that qualifies an individual for group membership.

Should the group struggle to engage in the topics of stress and trauma, facilitators could choose to highlight the apparent difficulty around discussing such subjects. Facilitators' acknowledgment that the group may not be in agreement about the stressful or traumatic nature of the various 9/11 experiences present in the room encourages the group to explicitly consider differences as they become apparent. In many ways, group members may be still be searching for footholds within the group, attempting to establish the common ground from which the group will conduct its business. If they feel comfortable doing so, facilitators can also make process interpretations around norms as they emerge, or to check in about the group members' experience of safety within the group in the context of self-disclosure. As various group members choose to engage or withdraw around the topic of stress and trauma, facilitators may find opportunities to normalize the various responses to stress that get reported within the group. Facilitators should be active in modeling support and appreciation for members as they discuss their experiences, but in an appropriate and titrated way. While some group members may experience relief and acceptance with such comments from the facilitators, not all members will feel comfortable with facilitators expressing appreciation or "making a big deal" about their contributions

Session 3: Effects of Traumatic Stress I**Facilitator tasks of session 3 didactic module.*****Describing an idiographic spectrum of traumatic stress impact.***

The purpose of the third didactic module to begin Session 3 is to resume an organized discussion around the various ways that traumatic stress affects individuals. Facilitators should be conscientious and deliberate in differentiating between stress and traumatic stress, and emphasize that the group will be spending the next two sessions looking at ways that traumatic stress (stress that overwhelms all available methods of coping) affects how people experience themselves, others, and their environment. Facilitators should feel comfortable in revisiting the idea that trauma is a phenomenon that seldom has only one precipitating factor. The previous session's discussion may have highlighted for many in the group the various stressful aspects of their collective 9/11 experiences. The third session will introduce the idea that just as various kinds and levels of stress in combination with other external factors can quickly or eventually overwhelm individual coping mechanisms and lead to psychological trauma, the effects of this trauma may manifest in a variety of ways, often without a linear or discernable timetable to the individual who experiences these effects. To this extent, how trauma has an effect on someone is largely idiographic. It is with this belief in mind that the curriculum will try to impart the notion that the effects of traumatic stress exist on a continuum and are commonly variable by individual.

All members of the group currently have certified mental health diagnoses through the World Trade Center Health Program, and are currently engaged in some form of outpatient treatment. The third and fourth didactic modules will introduce the diagnostic clusters of PTSD in a way that accommodates the various clinical presentations of group members. The separate

symptom clusters are used in combination to diagnose “full-blown” PTSD, but on their own each cluster shares various criteria with mood and anxiety disorders. These symptom clusters are useful for presenting the various distressing effects of traumatic stress in an organized way, but may fall short of capturing an individual’s experience. It is the assumption of this particular group curriculum that individuals may have various “sub-threshold” form of PTSD that present much more commonly as Generalized Anxiety, Panic Disorder, Persistent Depressive Disorder, etc. but that because they do not meet the specific criteria for PTSD, some aspects of their distress go unrecognized or get subsumed by the most disruptive or upsetting symptoms.

While the group curriculum does not seek to provide treatment for any one diagnosis or set of symptoms, a range of mood, anxiety, PTSD and sub-threshold PTSD disorders have been diagnosed through the WTC Health Program as a result of group members’ 9/11 experience. Many of these disorders share overlapping emotional and physiological symptoms that interfere with an individual’s ability to engage with their lives. All disorders by definition suggest difficulty in some area(s) of living, and thus the group can work to recognize the common ground they share in having been uniquely affected by a traumatic experience. Because the diagnostic criteria for DSM-V PTSD are expansive and include many of the same experiences of the depression and anxiety disorders that will be shared by group members, they can be presented by facilitators in the service of several goals. First, presenting the broad range of reactions to traumatic stress as the field currently understands it helps to provide education as to the spectrum of potential difficulties and responses. Second, the introduction of these symptoms by facilitators in the context of a 9/11 group will help to normalize and validate the disruptive and ego-dystonic phenomena that group members may have been working hard to disavow or ignore in their everyday lives (which will speak to the process of avoidance, described later in

this didactic module). Finally, group members will hopefully have a lower threshold for initiating self-disclosure during the group discussion, as they will be able to consider and even endorse reactions and experiences already introduced by facilitators.

Intrusive thoughts and re-experiencing.

One common reaction to traumatic stress involves the recurring, involuntary, and intrusive memories or recollections of an aspect of the traumatic situation. These memories may come in the form of nightmares, and often are accompanied by a strong physiological response. These intrusive thoughts or memories can also occur with a dissociative or “out-of-body” quality, and often are referred to as “flashbacks”. During flashbacks it is not uncommon for people to lose track of time or to become disoriented to their surroundings. These memories and recollections are different from deliberate efforts to remember because of their intrusiveness, and because they often elicit intense or prolonged distress after occurring. As their name suggests, intrusive experiences can be extremely disruptive and at times, debilitating. Intrusive experiences in themselves can become events to be feared and judged by those who have them, further contributing to the co-occurring difficulties of living with trauma.

Avoidance of thoughts, feelings, and external reminders of trauma.

Another common reaction to traumatic stress is the avoidance of both thoughts and feelings of the traumatic event, as well as active avoidance of external factors including people, places, objects, and activities that are related to the traumatic experience or elicit distress related to the traumatic experience. Facilitators can emphasize how, particularly in the wake of a traumatic experience, avoidance can be understood as a natural and expected part of human learning. Briefly facilitators can remind the group that humans have evolved to identify and avoid threats to their safety, and that this process gets disrupted by trauma- maladaptive learning

occurs when situations that no longer hold danger become identified by our bodies and minds as dangerous. To pre-empt the physiological and emotional distress of perceived danger (related in some way to a prior experience of actual danger) we find ways to avoid (both literally and figuratively) experiences that evoke distress. Avoidance becomes particularly problematic when it becomes generalized to thoughts, experiences, and activities that interfere with a person's daily life or desired level of functioning or enjoyment. A kind of secondary distress can be accompanied by problematic avoidance, wherein the realization of a loss of functionality or enjoyment (and more implicitly, a loss of safety) often results in shame, frustration, and disappointment. It is in these ways that we can see avoidance as a part of many different diagnoses and problems, particularly in the context of a traumatic experience.

Facilitator tasks of session 3 group discussion and process.

In Sessions 3 and 4, facilitators are tasked with providing more psychoeducation around expected and normalized responses to trauma. An inherent challenge exists in the transition between the didactic (which clearly implies teaching or instruction) and the discussion and process components of these sessions. This will likely be most evident (and most strongly felt) during Sessions 3 and 4, as the role of "expert" or authority will begin with the facilitators and hopefully move toward the group members by the end of the Session 3 and again at the end of Session 4. The facilitators at this point exist as their own subgroup in that they have not had a unique personal experience of 9/11 in the role of rescue or recovery worker. While facilitators presenting material about trauma and its range of effects establish themselves as holders of a particular kind of knowledge, group members exist as distinct from the facilitators in that they are each holders of their own experience. Facilitators must progress through the group sessions with the understanding that while they ultimately hope to instill the same knowledge that they

possess within the members of the group, they will not in turn be able to gain a first-person experience of 9/11 as a rescue and recovery worker. This transaction is necessarily lopsided, although it may require facilitators and group members alike to understand and tolerate this and other differences within the group. However, facilitators should progress in the knowledge that although every person present has had separate and different experiences that eventually led to joining the group, the experience of sitting and interacting as a group is an opportunity that is open to each person regardless of prior affiliation or group status.

Through the process discussions of the first two groups, the theme of “no one understands me” or “no one knows what I went through” may have emerged in some form or fashion. This sentiment may be projected upon families, partners, colleagues, employers, healthcare entities, etc. during group discussion, but facilitators may also hold the complementary belief that individuals may be expressing an aspect of their own uncertainty about their experience. “I don’t understand me” and “I don’t know what I went through” are sentiments that the early sessions in the group seeks to validate and address. By introducing two common reactions to the experience of traumatic stress (in Session 3: intrusive thoughts and avoidance) facilitators are beginning to provide a template against which group members can compare their experiences. The group discussion component of the group may serve as an opportunity for members to validate each other’s reactions in a way that was previously unavailable to them, by being able to lean on and draw support from the facilitators’ exploration of these difficult and unpleasant responses to acute or chronic exposure to traumatic circumstances.

Conversely, the introduction of the concepts of intrusiveness and avoidance very well may elicit a more defensive response, perhaps even in the form of denial. Such reactions should

be taken at face value by facilitators, rather than directly challenged. However, as facilitators may have a more developed sense of how trauma affects an individual's capacity to observe their own inner world particularly when they are activated by material related to trauma, several process interventions may be useful. One such intervention involves establishing a link between the concept of avoidance and the ongoing work of the group. Facilitators, having already introduced avoidance as a phenomenon that involves maintaining physical or conscious distance from a potentially distressing stimulus, can turn the group's attention to the possibility that avoidance gets practiced within the group discussion. Again, such an interpretation may be more appropriate if facilitators have recognized a pattern within the group wherein members appear disinterested in the proposed material, or if the discussion frequently becomes tangential to the point that it resembles casual conversation between strangers. While to an extent such behaviors are expected and certainly understandable, facilitators can feel justified in observing this pattern particularly if it emerges in proximity to a topic that may be related to individual's distress. The facilitator's role is not to enlist the agreement of the group, or to build consensus that such experiences apply to everyone, but rather to make the group a unique setting where members can ask themselves if such things are possible or have affected them personally. In this regard, the facilitators signal the transition of power and expertise back onto the group, inviting them to engage with each other and themselves around the ideas being presented in the didactic modules.

Another process interpretation that facilitators might make on behalf of the group could be to express the sentiment that many of the group members were asked as a part of their jobs to willingly and repeatedly expose themselves to dangerous and uncomfortable situations. Facilitators may make the observation that for many group members, their previous ability to "handle" stress and stress-inducing situations was a point of pride, and that the presence of

intrusive thoughts and feelings or the practice of avoidance must be extremely difficult to talk about for precisely these reasons. Facilitators may be called upon to model that there may be some benefit to talking about doubt, disappointment, and fear within the group. Such interventions seek to not only promote discussion about the very things that “no one understands” but to help make them feel more understandable to the group and the individuals that comprise it.

Session 4: Effects of Traumatic Stress II

Facilitator tasks of session 4 didactic module.

Brief review of intrusive experiences and avoidance.

Facilitators can begin Session 4 by reiterating that the purpose of both session three and session four are to introduce and discuss experiences that are considered common reactions to traumatic stress. While session three focused on the experience of intrusive thoughts and feelings as well as the active avoidance of thoughts, feelings, and external stressors as two of the ways people responds to exposure to traumatic stress, session four will seek to introduce two new but perhaps inextricably linked responses to traumatic stress. Facilitators can point out that for many of the group members who have discussed their experiences so far, it may have become evident that people share aspects of some or all of these responses to traumatic stress. More curious or treatment-savvy group members may have offered their understanding of their own diagnoses at this point, and facilitators can reinforce the idea that many of the experiences they are presenting overlap heavily with a variety of problems that individuals are already addressing in individual treatment. This will be particularly evident in Session 4, where mood and physiological reactivity will be explored.

Negative changes in cognitions and mood.

One aspect of enduring traumatic stress that has likely impacted many group members is that of negative changes in their cognitions and mood. Cognitions, for the group's purposes, can be understood both as thoughts as well as the processes by which we organize and store information. Cognitions are reflective of the way we "know" things about the world and ourselves. The term "negative changes" implies that there is a difficulty, deterioration, or disruption in cognitive functioning as a result of exposure to traumatic stress. One way cognitions are negatively affected is evidenced in difficulty for an individual to remember features or parts of the traumatic event, similar to partial amnesia. These could also relate to "jumbled thoughts" or memories when thinking about their experience of 9/11, as well as difficulty parsing out a linear progression of events around the times when traumatic stress was most strongly felt.

Further negative changes in cognitions include persistent negative beliefs about one's self and the world. For example, people who have endured traumatic stress may feel guilt or "bad", and may have adopted the belief that the world is "completely dangerous" or that formerly safe places or activities are now no longer safe. These negative changes in thoughts and beliefs can extend to the development of a distorted (intellectually unrealistic despite a felt truth or certainty) sense of blame of one's self or others for causing the circumstances leading to the traumatic stress or the resulting consequences.

As one would imagine such changes to thoughts and how information about the self and the world is processed could themselves be distressing contributors to a more negative emotional experience overall. Negative changes in cognition are associated with negative changes in mood as well. These changes include the presence or experience of persistent negative and dysphoric

trauma-related emotions such as fear, anger, guilt, and shame. Feelings of alienation and detachment from other people (even close family, friends, or romantic partners) are not uncommon, particularly in the context of negatively altered cognitions about one's self and the world. Negative changes to mood can be accompanied by a diminished interest in activities that were enjoyable, rewarding, or worthwhile to the individual prior to their exposure to traumatic stress. Such changes may be so strong as to prevent one's ability to experience positive emotions overall, and may range from volatile negativity to numbness as a result of constricted feelings. Many of these changes in cognitions and mood are similarly experienced in many major depressive and anxiety disorders.

Trauma-related changes in arousal and reactivity.

In addition to negative and disruptive changes to cognitions, thoughts, and mood, another way that exposure to traumatic stress affects individuals involves changes to the body and how it responds to its environment. While people often use their sensory systems to inform their thoughts and cognitions to help understand their environment and automatically provide our bodies with information necessary to respond appropriately to our environments, the experience of traumatically stressful events or circumstances has affected the ability to evaluate the self and the world in the normal, expected, pre-trauma ways. As such, exposure to traumatic stress is often accompanied by a difficulty in physiological regulatory systems that help to maintain the homeostasis required to function successfully over long periods of time. Instead, individuals may feel constantly "on edge" in a process known as hypervigilance, wherein individuals continually feel the need to assess for and anticipate potential threats in their environment.

Hypervigilance, which is a useful response in the presence of actual danger or a genuinely hazardous environmental situation (such as one that a group members may have been

in during a time of traumatic stress) can become disruptive and exhausting when it is involuntarily applied to every situation and scenario, most of which do not warrant the physical, emotional, and cognitive demands that hypervigilance requires. As a result hypervigilance is often accompanied by an exaggerated startle response, evidenced by “jumpiness” or sudden reactivity to novel stimuli (such as a door banging shut or someone sneezing suddenly). Because of an inability to feel calm and relaxed, people who have experienced traumatic stress frequently have problems with sleep and concentration, such that they are caught in an unfortunate loop of fatigue, anxiety, depression, and the accompanying negative thoughts about their current experience in addition to the already upsetting 9/11-related and traumatically stressful events that started this cycle.

Facilitator tasks of session 4 group discussion and process.

As in Session 3, facilitators are introducing a great deal of organizing content at the start of Session 4. They are reviewing the prior week’s didactic topics and again re-presenting Sessions 3 and 4 as complementary to each other. Session 4 introduces changes in cognitions and mood as well as the phenomena associated with hypervigilance, heightened arousal, and increased reactivity. The responses to traumatic stress that are introduced by the facilitators in session four may be more affectively provocative for the group, and during the process and discussion component facilitators should continue to monitor the group for reactions that may require intervention in the service of maintaining the “window of tolerance”. Facilitators have been modeling the discussion and process component of each group session as a containing and/or holding environment, and Session 4 should be no different. However, where group members may have risked self-disclosure in the prior session by discussing their own experience of intrusive thoughts or avoidance of activities, places, or reminders, this self-disclosure may

have been limited to the descriptions of these phenomena and their upsetting impact. In discussing changes to thoughts, feelings, and behaviors, facilitators should not underestimate the potential increase in risk and perceived peril within the group as this session may see a shift from self-disclosure statements such as “I have flashbacks of _____” to more intimate statements like “I feel guilty that I can’t stand being around my family”. By introducing the topics of shame, guilt, anger, and depression- the unwanted emotions caused by overwhelming past events- facilitators may have raised the stakes of the group.

While it is not possible to know or plan for the range of possible reactions within the group, facilitators can point out that talking about changes in cognitions and mood (if the group has demonstrated that it able to engage with these topics) requires both vulnerability and courage. While some of these changes may be well-known, even tiresome, to some group members who have been living with them for fifteen years, the group provides an opportunity to understand these changes and for individuals to experience less blame, guilt, and isolation through the exchange of mutual support and the process of bearing witness to members’ experiences. These thoughts may include substantial and pervasive self-blaming scripts in which group members “should have done more” within their 9/11 role, or “should have handled it better” when they were ultimately faced with the circumstances that overwhelmed their normal coping measures. Facilitators may observe that some group members are more enthusiastic about partaking in a discussion of their feelings, whereas others may seem troubled or withdrawn. Facilitators, having outlined clearly in previous sessions the role of safety and the assumed acuity of group members’ threat perception protocols, may feel comfortable checking in with the group around how some group members seem more ready to engage in this week’s discussion than in others. The facilitators’ approach of pointing out patterns of interpersonal

communication within the room and offering brief interpretations or questions for the group to make use of can be a good way to generate reactions as well as to take the temperature of the group.

A considerable potential benefit exists to having introduced negative feelings and heightened reactivity. Specifically, it is likely that the discussion of affectively-laden material (such as that shared in the group) will evoke affective responses from group members. Facilitators can make note of how different group members react during moments of particular intensity, as facilitators would be expected to have an emotional response themselves to identify such points. Although the didactic modules address in an abstract way various responses to traumatic stress, the group discussions that follow allow these reactions to become evident, albeit in more attenuated or controlled ways. Some group members may become more excitable than others, some more avoidant or circumstantial, whereas still others may retreat into silence and humbly state that they “just don’t have anything to say tonight”. Without singling any particular individual out, facilitators can highlight this for the group, and attempt to make connections between material that has already been presented and how the group finds itself conducting its business. The facilitators’ focus on the group’s interaction can serve as an example of how daunting establishing trust and safety can be, or if the group appears to be cohering well around their shared experiences, as an example of the work that has been done so far to help make the experience worthwhile for each other. Either way, process interventions and the group’s reaction to them help to serve the purpose of revealing to facilitators the individual conflicts and opportunities for growth both inside and outside of the group.

Session 5: Creating Individual Context for 9/11**Facilitator tasks of session 5 didactic module.*****Transition from introduction of didactic material to thematic material.***

In Session 5, facilitators will use the didactic component of the group to introduce material that is intended to provide a stimulus for the group during the discussion and process component to follow. In this way the didactic component of session five resembles the structure of the first four sessions. However, the Session 5 didactic module differs from its predecessors in that the facilitators are using the first part of the group session not to impart specific knowledge or to supplement existing information about stress, trauma, and their subsequent effects, but rather to focus the group's attention on particular ideas that may help to address the group members' experiences in novel and (hopefully) useful ways. The term "didactic" applied accurately to the facilitators' efforts during the first four sessions, wherein specific clinical concepts were introduced based on the facilitators' understanding of them. The beginning of Session 5 applies the term didactic to the facilitator role in a less literal sense. Facilitators will continue to offer material that the group can attempt to make use of, although the material itself will be more thematic in nature and less psychoeducational or related to a specific clinical experience. Session 5 seeks to explore the broader context of 9/11 for each individual through the lens of stress and coping. In this way it is an effort to begin the formation of an individual narrative, an exercise that will hopefully continue over the remainder of the group sessions.

Identifying prior life stress and ways of coping before 9/11.

At this point of the group, stress and coping have been introduced as relevant topics since the start of session two, when stress was understood to be a normal and expected part of human existence. Coping was introduced and understood as conscious and unconscious ways

individuals respond to the experience of stress so as to preserve themselves and tolerate the experience of stress. Trauma was then introduced as an experience or set of experiences that in some way (either all at once, or over a period of time, either acutely, or more insidiously) overwhelms the set of coping strategies an individual has to employ against stress. As a result, the emotional, physical, and spiritual integrity of the individual becomes compromised following the experience of traumatic stress, resulting in a variety of distressing and often maladaptive ways to live outside of the traumatic environment. Given this linear and somewhat simplified understanding of how trauma occurs, facilitators will prompt group members to consider themselves “before the beginning”- before their role in the 9/11 rescue and recovery effort resulted in the immediate or eventual distress that they have endorsed.

Facilitators should advance the goal of each individual being able to understand the context in which their own experience of 9/11 began so as to better understand its impact on the individual. For example, facilitators can prompt group members to recall their level of stress in relation to their roles prior to the sudden and unexpected events of September 11th, 2001 and the ways in which they were coping with their “normal” life stress before the attacks began and they were tasked with a role in relation to the disaster. Group members should be asked to consider ways in which they recall dealing with stress before 9/11, and to gauge how successful they felt those efforts had been at the time. Because of the assumed presence of stress and coping as part of everyday life, facilitators should ask group members to consider how they felt before 9/11, before they were taxed by the additional stressors of both 9/11 as an event and their role related to it. Ideally, this consideration will yield for each member identifiable ways they historically had coped with stress prior to 9/11. Such (conscious) coping strategies may have involved spending time with family, talking about difficult issues with colleagues or trusted friends,

activities like sports or creative pursuits, or more routine but important rituals such as sleeping in one's own bed or cleaning one's home.

Stress related to 9/11 role and subsequent impact on normal coping.

The identification of previous ways of coping, the recognition of formerly stress-relieving interactions, relationships, and activities provides a personal and historical starting point for group members from which to consider the last fifteen years and into the present. Through the four previous sessions, group members have likely discussed the nature of their role and what their responsibilities included. While it is assumed that the group will be heterogeneous in terms of the various roles and affiliations present within the group membership, the group members all share a common historical experience in that they were pressed into service, either through a professional or volunteer role, in order to respond to and address the events of 9/11. While the nature and demands of these different roles may have varied greatly and can reflect the different kinds and intervals of traumatic stress endured by the group, these difference may be less significant to the group's broader recognition than the facilitators' emphasis on the idea that each of them in some way had their normal ways of dealing with stress challenged or overwhelmed.

Just as the facilitators prompted group members to identify the various strategies they used to cope with normal stress prior to their 9/11- related role, facilitators should then ask group members to consider ways in which these "go-to" activities, strategies, or relationships were compromised because of, during, and/or in relation to their particular role during 9/11. For example, individuals who suddenly had to spend days away from home and families in order to be in close proximity to the hazardous work environment in which they were expected to work until the point of exhaustion likely had their coping reserves depleted quickly. Moreover, the demands of various 9/11- related roles may have meant there were few opportunities for

individuals to employ their useful coping strategies or to cultivate adaptive alternative coping methods. For some individuals this process may have taken place quickly and suddenly with the loss of friends and colleagues, or with the sustainment of bodily harm or injury. For others, the point at which normal coping was overwhelmed may have come days, weeks, or months after September 11th. The cumulative impact of different 9/11 roles is relative to each individual's pre-existing capacity for coping with stress. That 9/11 was both a destabilizing and frightening experience for millions of Americans not in any way related to the rescue and recovery effort speaks to how compounded and intense the experience has been for group members who were more directly involved in its aftermath.

Continued life stress and ways of coping following 9/11 role.

Finally, just as facilitators are prompting the group to consider ways in which their methods for coping existed prior to and potentially changed or were overwhelmed during 9/11, the group focus should also include ways that stress has been handled following 9/11 and how they have managed to cope with stress since the conclusion of their 9/11-related responsibilities. Facilitators can make explicit the idea that given the understanding of the relationships between stress, coping, and trauma that have been discussed, it can also be assumed that exposure to traumatic stress has long-lasting impacts on one's ability to cope with "normal" or everyday life stress in the same ways they had been able to prior to their 9/11 experience. For many the threshold for what elicits a strong emotional or physiological response, perhaps to the point that the response is experienced as frightening or overwhelming, is indicative of the long-lasting impact of a traumatically stressful experience. However, facilitators can also accommodate for the very real possibility that group members have found ways to make situations more tolerable, or at the very least they can recall a time when their coping was more compromised than it is in

present day, giving an indication of some adaptive coping process. As a broader message, facilitators want to get the group to think about the ways their sources and levels of stress have changed since just before 9/11 all the way through to the present day. It is likely that group members may perceive a significant deterioration in the current ability to cope with everyday stress, but it is also possible that many have made gains through their individual treatment efforts or by developing more effective means of coping with stress.

Facilitator tasks of session 5 group discussion and process.

During the first four sessions, facilitators have been tasked with providing a fair amount of conceptual and clinical material at the start of each session, and trying to guide the group around to a focused discussion of the topics introduced. The process and discussion component of Session 5 will be similar in this regard, although facilitators may find themselves having a less active role while wanting to make sure that the group time is managed efficiently. For example, the first part of the session involves the facilitators providing a rationale for the group members to consider the history of their stress and coping responses in the context of their 9/11 experience. The discussion and process component of the group should then focus primarily on this topic, with members sharing their accounts of how their stress and coping was impacted or changed as a result of their 9/11 role and responsibilities. Group members may have difficulty being able to clearly recall how well they coped with stress in the past, and brief interventions offered by the facilitators (e.g. “What changed for you the most?) may be useful. Facilitators should also feel comfortable in circling back to material covered in prior sessions if necessary, for example drawing connections between an individual’s difficulty with present-day coping and the previously discussed effects of and responses to a traumatically stressful experience, where appropriate.

Just as in any session thus far, facilitators will not be able to wholly predict the range of member responses that this area of discussion elicits. However, facilitators should be prepared with how they will manage an exploration into coping that may result in a strong affective response within the group. One such example of this would be the topic of substance abuse as a means of coping, or the admission that a group member resorted to physical violence or intimidation as a means of coping with stress. For individuals who have experienced traumatic stress, such behaviors are not uncommon, although the opportunity to relate these episodes or behaviors to a prior experience and attempt to integrate them into a larger personal narrative related to 9/11 is much rarer.

Facilitators can emphasize the significance of various changes in coping for different members of the group while also drawing attention to the response of the group as a whole as self-disclosures are made. However, it may also emerge that a group member did not have established or adequate methods of coping with stress prior to 9/11. Such a discussion remains relevant to the group because even in instances where there was a lack of effective or adaptive coping in response to normal stress prior to 9/11, the eventual additional stressors that accompanied an individual's 9/11-related role likely led to further decompensation or inability to engage in supportive resources. If the timing and current level of cohesion within the group feels appropriate to the facilitators, a facilitator may make the observation that it appears that the group members present have elected to participate in a new form of adaptive coping by attending the group. Such a remark could be met with a variety of responses (silence, laughter, eye-rolls, sincere agreement, etc.) but regardless of the group's response the facilitator again offers the belief that the group and its members as an important source of support and understanding for both present-day difficulties and their experience of September 11th.

Session 6: Understanding 9/11 as a Private Life-Changing Event**Facilitator tasks of session 6 didactic module.***Understanding personal changes following 9/11 role.*

Through the first five sessions, group members have been asked to co-create a “safe enough” environment to discuss both their own personal experience of 9/11 and the facilitator-initiated focus around the concepts of stress, trauma, and coping. In the remaining five sessions, group members will continue to have their attention directed toward themes and ideas that hold potential relevance to their individual experiences of 9/11. Whereas in a more open-ended group therapy model many of these themes might emerge over the course of several weeks or months and be revisited by the group, the time-limited nature of the group curriculum prompts facilitators to introduce such concepts as possibilities, and welcome the group’s reactions or feedback. Where possible, facilitators should continue to find opportunities to establish links to material presented in previous sessions. One such opportunity exists in the examination of the personal impact each member’s 9/11 role has had on how their lives have continued in the wake of 9/11.

Through the very fact that they are enrolled in the WTC Health Program and have continued to participate in the group, individual members have acknowledged that their role in the response to 9/11 has impacted them in a significant way. Facilitators should acknowledge that many group members have used the previous sessions to discuss ways in which their ability to cope with situations and stress has changed since 9/11. As a result, facilitators can advance the hypothesis that group members may view 9/11 as an intensely personal experience that affected the trajectory of their lives in a multitude of potentially unknowable ways. Facilitators should present the sixth session as a chance to explore these changes that have occurred since

9/11, but also to gain a greater appreciation of the complexity of each person's circumstances and lived experience.

As a part of advancing this hypothesis, facilitators should support the idea that while it may seem difficult or impossible to directly attribute some negative life events (such as a divorce or the loss of employment) directly to a member's role in the 9/11 rescue and recovery effort, the group's current understanding of the cumulative and interconnected nature of stress, trauma, and coping can reveal how potential vulnerabilities to stressful events may have manifested more acutely following their 9/11 role. Facilitators can point out that life events like forced early retirement, changes in close relationships, difficulties with sex and intimacy, lost social and professional contacts, financial problems, and other seemingly "non-9/11" problems can in fact be related to a group member's experience of 9/11. For others, negative life events may appear more concrete or easy to attribute to their experience of 9/11, such as in the case of health problems caused by chronic exposure to hazardous conditions or due to injuries received while working in within their role in the 9/11 rescue and recovery effort. Facilitators want to welcome and initiate the reflection on past and present difficulties experienced by group members in the context of 9/11. This effort can normalize and accommodate the experience of expected stressful life events but also prompt their consideration as events that are connected to an individual's experience of 9/11.

Acknowledging conflict around impact of 9/11.

By deliberately presenting the possibility that the roles and responsibilities of the 9/11 rescue and recovery effort affected group members in long-lasting and reverberating ways, facilitators validate a question that many members continue to ask themselves: "Are today's troubles my fault or were they caused by 9/11?" Such an unanswered (and potentially

unanswerable) question captures a conflict many group members may feel, either through their own struggles to answer it or in justifying the answer they have decided to adopt. Facilitators can point out that because 9/11 brought with it an unprecedented and completely unexpected amount of stress into each group member's life, it is unlikely that any area of their psychological and emotional life went unaffected by it. As the first five group sessions have advanced the idea that 9/11 impacted the group members' abilities to cope with stress both during the experience of their rescue and recovery role and afterward, Session 6 represents a more focused look at the specific venues that have been affected for each group member.

While for some individuals there may be a measure of relief in "blaming" an aspect of their 9/11 experience for difficulties experienced in the present, there may also be tremendous guilt and shame in the context of any contradictory evidence that suggests that some problems existed well before the year 2001. In contrast, the urge to disavow the experience of 9/11 as "an excuse" for current suffering or difficulty speaks to a potential conflict around how much support one is entitled to, and a potential self-sacrificing impulse to turn blame inward rather than risk acknowledging the possibility that one was affected by terrible circumstances that felt beyond their control. Facilitator interventions represent a more neutral and inquisitive stance by introducing the idea that regardless of where individual group members stand in how they view their current problems, it would appear that most efforts to reconcile the conflict around to what extent 9/11 is responsible for current experiences have been unsatisfying. Facilitators can again affirm the significance of the impact that 9/11 had on group members' ability to cope with life stress, and acknowledge the frustration and confusion that can occur in trying to gain contextual understanding of a traumatic experience while simultaneously living with its effects on mood, cognition, and physiology.

Recognizing grief for personal losses.

For many group members, it may be difficult to acknowledge that 9/11 affected the trajectory of their lives in negative and unforeseeable ways. Facilitators should acknowledge that the previously discussed negative changes in mood and cognition may make the prospect of deliberately attending to loss and grief unpleasant. Additionally, the ideas of grief and loss may elicit negative self-judgment and shame. However, facilitators can speak to the importance of grief as an expected part of dealing with loss, and suggest that difficulty in acknowledging losses following the experience of 9/11 can be representative of an interrupted a grieving process. Through the deliberate albeit painful acknowledgment of losses and attempts to gain emotional resolution around their existence and impact, individuals avail themselves of additional emotional and attentional resources that have previously been allocated to defensive processes that have formed to protect from the pain of such losses (Courtois & Ford, 2013). Facilitators can draw the group's attention to the consideration of these losses for each member, and promote the sentiment that just as trauma is relative to those who experience it, so too is the experience of loss and grief. With this in mind, facilitators will ask group members to discuss the losses they incurred following their experience of 9/11 in an effort to allow for the start of a shared grieving process.

Facilitator tasks of session 6 group discussion and process.

The facilitators use the presentation and didactic component of session six to ostensibly focus on the conflict that has likely existed within individual group members around how much they have lost, and how much of what has been lost is because of 9/11. By articulating this conflict, facilitators are attempting to provide a platform for additional group work to be done. In many ways, the group has been an opportunity for group members to bear witness to each

other's accounts of their experience of 9/11 and the years that have followed. To an extent, group members have also witnessed each other's experience of being in the group itself. The extent to which the discussion and process component of Session 6 reflects the status of the group's level of safety and cohesion will be evident in how the group reacts to the facilitator's suggestion that the time be used to consider individual losses.

The oft-referenced challenge around and unpredictability of anticipating group work revolves around the idea that each unique version of a group milieu will respond in its own way to the facilitators' introduction of material. Session 6 may see the emergence of several different reactions, and each reaction may have a particular meaning within the group that can inform facilitators' observations. With this in mind, group facilitators should not be entirely surprised to find that group members may not be in agreement with the idea that their 9/11 experience has affected such seemingly tangential aspects of their lives. For these group members, the internal conflict around the attribution of blame and accountability may become externalized, presented as a challenge to the facilitators or other group members. Facilitators can observe that such a reaction may suggest a desire to avoid the work of identifying losses. The facilitators' efforts to convey empathic neutrality in how they make such an interpretation is important, as an ensuing power struggle could be both an emotionally activating and ultimately counterproductive diversion from the group's work.

Alternatively, the group may identify with the ideas presented by the facilitators and demonstrate a capacity and willingness to express their own experience of loss following 9/11. For some the group environment may provide an unprecedented opportunity to recognize the painful disappointments and difficulties that have emerged out of their 9/11 experience. To the extent that the group has co-created a level of safety to encourage such self-disclosure, mutual

support and interpersonal learning occur around the shared recognition of unprocessed losses and difficulties.

While these two potential responses represent different ends of an entire spectrum of reactions from within the group, for the facilitators it will be important to remember that one response is not necessarily more desirable than another. In presenting an emotionally provocative idea and prompting group members to consider losses, the facilitators should not feel pressured to evoke an “ideal” response. While it would likely be less anxiety-provoking for facilitators to feel that the group is totally cohesive and in agreement with each other, to an extent this may be less helpful than a group that has difficulty achieving a consensus around loss and grief. A more important aspect of the group’s behavior for facilitators to take note of revolves around the expression of affect and the group’s ability to tolerate and even respond to such expressions. Facilitators can draw attention to group members’ efforts to convey their experiences or support one another, going so far as to frame such statements as gifts. During moments of disagreement or opposition, particularly those accompanied by strong affect, facilitators can praise group members for simultaneously modeling honesty and restraint for the other group members. In this way, a prognostically valuable response at this stage of the group would consist of the expression of strong affect in relation to 9/11-related content that is then recognized and contained within the group. Facilitators can observe that such expressions speak to a degree of health within the group, particularly a group that is able to tolerate disagreement without disintegrating or withdrawing, as the effects of traumatic stress might suggest as a possibility.

Session 7: Understanding 9/11 as a Shared Event*Distinction of 9/11 as both a personal experience and part of shared national history.*

Whereas Sessions 5 and 6 sought to cultivate a sense of how the events of 9/11 affected members of the group individually, Session 7 seeks to provide opportunities for the group to consider 9/11 as an event that had a broad social, cultural, and political impact. The unexpected and unprecedented scope and devastation of the September 11, 2001 attacks brought notoriety to the date's events, sure to be considered alongside other tragic events in American history for decades to come. As a result of this certainty, group members may find themselves embedded in a national climate that mirrors their own ambivalence regarding how to cope with the events of September 11th, 2001 fifteen years later. Session 7 seeks to engage with and validate the challenge faced by the group members who experienced 9/11 on a more personal level than the millions of Americans who witnessed 9/11 at a greater distance.

Whereas many individuals who have experienced a personal or shared trauma may have the experience of having only their own memories or the accounts of others who experienced their same specific circumstances to serve as reminders of the traumatic events, 9/11 rescue and recovery workers occupy a distinctly different space. The events and images of 9/11 have taken on historical and political significance so far beyond the control of the group members who experienced their own perspective of 9/11 events such that it is possible to feel disconnected or alienated from the more broadly adopted mainstream views of the day's events. In many ways, the narratives disseminated by various entities through media and political platforms exist alongside but separate from the experiences held by the group members who lived and worked in the shadow of the tragedy itself. Session 7 hopes to acknowledge the challenge of finding one's

own narrative within the various perspectives and stories that have sought to wring any variety of meanings or impose any number of agendas in relation to the events of 9/11.

Facilitators can reinforce the significance of the group member's presence for each other in this way, as they each contain a perspective of 9/11 that differs from the perspectives found in movies, television, and books. Group members may endorse that they all share both the privilege and the burden of having been a part of the rescue and recovery effort which has left them with a different overall sentiment about 9/11 than those that are absorbed by the broader American culture and ultimately inform the majority view of 9/11's historical significance.

Limitations and challenges of mainstream perspectives of 9/11.

Facilitators can point out that unlike other potentially traumatic events that are experienced by individuals, the 9/11 attacks were of such intensity and significance that they have inevitably been co-opted by other people, organizations, and causes. For group members questions around ownership and entitlement may persist, suggesting a tension between discomfort with labels like "hero" while simultaneously endorsing pride and a desire for recognition of their work in the rescue and recovery effort. In this regard, some group members may feel in some way marginalized or undercompensated for their experience, whereas others may feel uncomfortable with praise or appreciation due to their role affiliations, particularly when these sentiments are at odds with their own conflicted feelings. While each individual's role and experience has likely influenced the extent to which they specifically are affected by this tension, the group offers an opportunity to understand this ambivalence and to validate the strong feelings that stand in opposition to each other.

As post-9/11 America coalesced around a shared historical narrative of decade-old events, group members may have been dismayed to observe the routinized acceptance of 9/11

into the nation's history- to witness as 9/11 lost the immediacy it once commanded and instead integrated into the same linear timeline occupied by events of great (but distant) import. For those who experienced 9/11 at a distance and in the continually evolving context of the social, political, and cultural ripple effects that emanated from it, the resulting perspective is compressed and more limited- in stark contrast to the group members for whom the events of 9/11 remain salient and unforgettable. Such disparate perspectives of 9/11 as those taken by group members compared to the broader society in which they continue to live may breed feelings of alienation, resentment, and hopelessness. The potential focus of Session 7 is for group members to articulate and endorse these challenging feelings which continue to influence the relationship each group member has with their own experience. Facilitators can recognize and explore the dissonance caused by group members' experience of living alongside a broader cultural narrative of 9/11 that does not necessarily corroborate or accommodate their own.

Facilitator tasks of session 7 group discussion and process.

At the start of Session 7, facilitators move the focus of the group's attention from their internal experiences as individuals to their internal experiences as members of external groups. By emphasizing the feelings related to being a member of a particular group (for example, the NYPD, a teamster's union, a volunteer firefighter, etc.) group members may also find opportunities to express feelings about other groups, including the current therapy group itself. Because of the group heterogeneity, there may be potential disagreements or tensions between group members from different affiliations. In as much as these tensions may emerge in the form of in-group behavior, facilitators can comment on the complexity of an individual assuming multiple group memberships simultaneously. Some may feel like "official" groups such as the NYPD and FDNY received recognition and other benefits for their role at the expense of

deserving but less prominent or recognizable groups (e.g. volunteer professionals from a neighboring state). Members may carry ambivalence about their group affiliation, feeling burdened by the expectation that they adopt the mantles bestowed upon them by a supportive and well-meaning public, whereas other members may have experienced envy or disappointment at not receiving the same support. Such potential for disagreement over differences in group membership and individual experience can be observed by the group facilitator and commented on as a potential point of work within the group, and the potential meaning behind the ability of this group to validate and empathize with each other's experiences despite (and simultaneously, in the service of) their differences. While individuals will likely not have an opportunity to make their frustration, disappointment, and anger (among other feelings) known to society at large, the group offers the chance for the individual to be heard and understood by others who have had a version of their experience.

In encouraging discussion around the topic of groups and entities that have failed to recognize the scope and severity of the difficulties 9/11 has caused the people who were affected by it, facilitators may also be welcoming the verbalization of strong transference reactions to the WTC health program as a whole. Such institutional transference may manifest itself in covert statements like "I wonder why it took so long for a group like this to get started anyway?" or more direct expressions of frustration or disappointment like "Well this program will only last until they decide to fund something else, then we'll get the rug pulled out from under us." While only serving as an example, facilitators can explore the "us" and "them" dynamic as it exists in the group. Facilitators may find that depending on the session they may feel more "them" than "us" based on the emergence of other group leaders and as the group moves away from relying on the facilitators for structure and containment. Moreover, such expressions of aggression or

disappointment may be quickly followed with efforts of undoing (“Just kidding, you guys are great...”) that highlight some of the struggles with attachment and interdependence some group members may have.

Finally, during this discussion of groups and the accommodation of narratives, facilitators should be attuned to potential references, made either directly or obliquely, to the prospect of the current group ending. In the event that group members are touching upon themes that may reflect some concerns about abandonment or separation (such as an expressed anxiety about the WTC Health Program shutting down) facilitators should attempt to try to guide the group toward addressing the prospect of eventual termination. Barring a discrete or explicit opportunity presenting itself within the content of another group member’s speech, it may be helpful (and necessary) for the facilitators to comment on the prospect of termination. The idea of the group ending may be met with any combination of indifference, anxiety, or dismissal, but facilitators should work to ensure that the topic is brought to the group before the end of Session 7. Just as group members may be hypervigilant and constantly scanning their physical environment for potential threats, facilitators should hold the belief that group members may also be hypervigilant and attuned to sudden or impending loss. In order to further engage with the topic of loss (in this case, the loss of the group time and the shared dynamic) in a healthier and more adaptive way, facilitators can model transparency and consideration for the group by bringing it to the forefront of the group’s attention. Facilitators can assert that impending end of the group may activate some familiar reactions or patterns within group members. By recognizing the reality of the group’s limited time together, facilitators again invite a discussion of the “here and now” that can hopefully be related to an individual’s experience of how 9/11 impacted them.

Session 8: Identity and the Self after 9/11**Facilitator tasks of session 8 didactic module.***Assumptive changes in understanding of the world.*

In the beginning of Session 8, facilitators should review the themes that emerged from the previous session, particularly those around feelings of isolation or separation from other groups- families, colleagues, and the broader society in which all members are embedded. Facilitators can then speak to the idea of 9/11 as an event that affected how many people, and group members in particular, saw the world. Session 8 does not seek to bring in entirely new or complex material, but rather to organize the content of previous sessions in a new way that generalizes to the members' experiences beyond the group.

The concepts introduced at the start of Session 8 are borrowed from Dr. Ronnie Janoff-Bulman's (1992) theory about trauma as an event that disrupts foundational assumptions that all individuals tend to make in order to function and survive. Two of her assumptions involve commonplace human beliefs about the world. The first is that the world is an ordinarily benevolent place, and that in general the people who inhabit the world are good, with values that favor decency and fairness as an innate principle despite negative behaviors, actions, and events. A second assumption proposes that the world and its events are in some way meaningful, and connected to a sense of fairness. Derived in part from Dr. Melvin Lerner's "just world hypothesis" (1980), this assumption presents the world as a meaningful environment where good people are rewarded and bad people are eventually punished as part of a larger existential justice. In the context of the wide-scale destruction, loss of life, and innumerable tragic consequences of the 9/11 attacks, these assumption were disproved, compromised, and in the terminology of Janoff-Bulman, "shattered".

The “shattered assumptions theory” proposed by Janoff-Bulman highlights how traumatic events exist as intrusive and overwhelming experiences that undermine an individual’s previous way of organizing and understanding the world. In the wake of a traumatic event that so clearly demonstrates the world’s capacity to be random, malevolent, and without meaning (such as the events of 9/11), individuals may experience a shift in assumptions about the world that move toward cynicism, vigilance, and guardedness. It is also important to recognize that these new assumptions can be congruent with an individual’s symptoms, such as those described in Sessions 3 and 4, but create difficulty in situations that require trust, vulnerability, intimacy, and flexibility. In many ways trauma can leave individuals with the (understandable) determination to not be traumatized again, and to form a new conceptualization of the world in order to fit their lived experience of their symptoms.

Group members experienced the events of 9/11 from a different perspective than millions of people who also had their assumptions about the world challenged, but in very different contexts. As reviewed in the literature, duration of time spent on or near affected disaster sites has been highly correlated with increased physical and mental health problems. Many group members were exposed to hazardous environmental conditions in addition to enduring the physical and emotional strain of performing their role in response to 9/11. For many people who were involved in the rescue and recovery efforts, the reality of the unjust, unpredictable, and intentional violence of the 9/11 attacks stood in stark contrast to any assumptions about the world as a benevolent and meaningful place. The loss of a meaningful and benevolent world was imposed upon group members in combination with any potential pre-existing biopsychosocial stressors and, and in many cases was accompanied by a perception of persistent threat resulted in a disoriented and chaotic experience of the world.

Assumptive changes in understanding of the self.

In addition to shattered assumptions about the world as a benevolent and meaningful place that is comprised of well-intentioned but flawed people, group members may also be struggling with shattered assumptions about themselves. Session 6 asked group members to consider the changes that they had seen in themselves following their 9/11 experience, and many of these changes can be accounted for by a broken former belief about one's self. Janoff-Bulman's third assumption that is violated by trauma pertains to the idea that it is common for individuals to consider themselves as positive, moral, empowered. Such an assumption about the self supports the idea of agency, and for individuals to accomplish tasks effectively and achieve desirable outcomes as a result of positive autonomy. To this extent, this third assumption includes the ideas that the experience of most undesirable or negative outcomes can be largely avoided in a just world provided a person is able to make good decisions. As 9/11 demonstrated, this assumption can be destroyed along with lives and buildings. However, just as pre-9/11 assumptions about the world and the self were changed under dire and unpleasant circumstances, this change also suggests hope current assumptions about the world can be changed- albeit with experience of 9/11 incorporated into a new worldview.

As survivors of some degree of traumatic stress, group members are left to reconcile the difference between their pre-9/11 worldviews and their experience during and since their role in the rescue and recovery effort. Facilitators should present these assumptions tentatively, and guide the group to a discussion of how an event like 9/11 can be incorporated into a view of the world that sees people, events, and outcomes as neither all good nor all bad. As the group has already discussed the many ways in which their lives and experiences have become more rigid and limited since the completion of their 9/11 role, facilitators can prompt a discussion around

group members' current views of the world. Such a discussion can hopefully increase the group's ability to identify outside experiences that contribute to the development of more flexible worldviews, as well as to experience each other in a way that feels well-intended and meaningful.

Facilitator tasks of session 8 group discussion and process.

In the group discussion of Session 8, facilitators can prompt group members to share their own interpretation of how they view both the world and themselves following their experience of 9/11. Many of the ideas that are related to the shattered assumptions have been discussed in prior groups, but the group discussion can hopefully serve as a way for group members to modify or adapt their current assumptions. A more cohesive working group is itself contradictory evidence to the world as an overtly hostile place. Some group members may even be able and willing to communicate that they have come to feel safety within the group that they are not able to replicate at home or in other settings. For some individuals this experience, either through their active participation within the group or through the recognition of a similar process occurring for another group member, may contain both novelty and power.

A successful group has been able to serve as a container for the anxiety, anger, fear, guilt, and embarrassment of its members. Simultaneously, it has also been able to serve as a vehicle for the expression of humor, irony, appreciation, friendship, and hope. The extent to which the group can value the expression of both positive and negative affect without experiencing the subsequent and familiar patterns of volatility and isolation indicates a trajectory toward health and the shaping of new assumptions about self and others. Facilitators can prompt a present-focused discussion by responding to any evident changes in how group members interact or the extent to which self-disclosure occurs within the group. Group facilitators may also present the

group's development as a demonstration of the group members' ability to adapt or modify previously held assumptions. The anxiety and uncertainty of the start of group may have reflected broader assumptions about the nature of groups or the prospect of self-disclosure as threatening or potentially harmful experiences. It is more likely than not that there will remain a sense of risk and potential danger for many group members. However, facilitators can point out, where applicable, how these feelings have become more tolerable and have not precluded individuals from participating in meaningful ways.

Given the group's more developed understanding of how traumatic stress impacts the ability to cope with later stress, the group's continued existence is evidence of adaptability. Had the initial levels of anxiety or discomfort experienced at the start of the first session persisted, it is unlikely that session eight (or perhaps even session two or three) would have occurred. Facilitators should support and reinforce this accomplishment, and explicitly point out the group member's shared capacity for change and adaptation in response to a new situation. Facilitators should again point out toward the end of session eight that a new situation is indeed awaiting the group; that of termination and the group's pending dissolution. Again facilitators must assume the mantle of responsibility for bringing termination to the forefront of the group's consciousness. While unpleasant to acknowledge, the developing and increasingly secure environment developing within the group will inevitably conclude in its current format. Facilitators should urge group members to consider how they wish to use the remaining two sessions together in an effort to help make the end of the group both a useful and meaningful stage worthy of its own attention, instead of an abrupt and unprocessed disappointment or relief.

Session 9: Termination I**Facilitator tasks of session 9 didactic module.*****Clarification of format for sessions 9 and 10.***

At the start of Session 9, group facilitators should allow the group to organize and begin in its usual manner. Whereas the first eight sessions of the group have included what has been referred to within the curriculum as a “didactic” module, the last two sessions are dedicated entirely to the process of termination and attending to the group’s conclusion. Because no new structural concepts or psychoeducational materials are going to be introduced in the last two sessions, facilitators should begin by explaining that the last two groups will operate as discussion and process groups for their entirety. They should also point out that this will mean that the usual brief break will be omitted from Session 9 and 10. Therefore, if any group members had planned on using the break they should feel free use the facilities or attend to whatever concerns they have at present, as the group will not be pausing at the twenty minute mark. To this (literal) end, facilitators should provide the rationale that they wish to respect the conclusion of the group as an important experience, and to provide group members with ample opportunity to consider the emotional and experiential impact of the termination phase as it occurs.

Facilitator tasks of session 9 group discussion and process.***Emphasizing end of group as significant stage of treatment.***

By the start of Session 9, the facilitators have referenced the end of the group as a topic that is in many ways easy to avoid thinking about. The urge to adopt an attitude of “we’ll cross that bridge when we come to it” toward the prospect of group termination is reflects a strategy to defend against the pain of loss, or at the very least to defend against the uncertainty of future

change. In this way, the avoidance of the reality that the group in its current format will no longer continue may resemble group members' tendency to practice avoidance in other situations and relationships. The end of the group can be realistically presented as both an impending loss but also a developing opportunity. Change, considered as an inevitable and largely unknowable force that impacts every human life, brings with it altered meanings, emotions, and understandings. The end of the group is a change that is imposed upon group members and facilitators alike, but with the unique and potentially valuable caveat that the group can acknowledge this particular change together, and in ways that differ from previous attempts to respond to change.

Acknowledging ambivalence in context of termination.

Facilitators also have the responsibility to point out that while the group is approaching termination, it is not yet time to say goodbye, and valuable work can be done in the final two meetings before termination. For example, the prospect of termination can cause familiar patterns of coping with the end of relationships to emerge within group members. To the extent that it is possible facilitators should attempt to bring this up within the group and to relate it to previous themes and content discussed through the first eight sessions. The end of the group brings with it a variety of thoughts and feelings for each group member (and the facilitators). Therefore, the end of the group provides an opportunity for each person to learn more about he or she copes with endings. In some cases, feelings may be very mixed and the group may see some regressive or even maladaptive ways in which individual members attempt to cope with the end of the group. Some of these patterns may have become evident over the last several sessions (such as a decrease in participation or late/inconsistent attendance from a particular group member) whereas other patterns may emerge the more finite and real the group's end becomes.

Group members may move to protect themselves from loss by disengaging in discussion or making statements that devalue the group, an attempt to dismiss its importance or impact in lieu of expressing a disappointment in the loss of the group, or a disappointment in what the group lacked, or a feeling of relief that may be associated with the end of obligations toward the group. Similarly, circumstances that exist outside the group may be experienced as particularly threatening or overwhelming at this time, with group members asserting that they need the group's help now more than ever. Each of these reactions, as well as many others, can be explored within the group. Facilitators should note if the group is able to engage in these topics or if the group moves quickly toward more superficial or surface-level discussions, perhaps in an attempt to keep the discussion limited to less uncharted territory (and by extension, feelings). In short, facilitators can emphasize that the end of the group is a chance to learn and understand one's self in the context of an unavoidable change. Just as the rest of group members' lives will be subject to circumstances they can neither control nor predict (a tendency that for many group members may be strongly associated with the traumatic stress experienced around 9/11) the group's end is an *in vivo* experience of change. The potential for group members to learn about how they cope with change (as well as grief, loss, or distress) in the holding environment of the group is a crucial component of what the group offers to its members.

Session 10: Termination II

Facilitator tasks of session 10 group discussion and process.

Identification of group themes and clarification of group identity.

The final group meeting will likely be an affectively charged experience for both facilitators and members alike. Facilitators will have the challenge of managing the group's time effectively while also cultivating a climate of mutual reflection among group members.

Facilitators may feel particularly compelled to “end on a high note” or to offer the gift of a “happy” ending to the group members. While these feelings are understandable, and are most likely rooted in the facilitators’ benevolent wish to have been helpful, they could also obfuscate some meaningful work around how disappointing and sad endings can be. By anticipating a spectrum of reactions and feelings in response to the group’s end, facilitators can help to make the end of the group survivable. While much of the group’s work has been focused on losses and conflicts following their experience of 9/11, the end of this particular group offers the opportunity for group members to have been treated fairly, with respect, and with the understanding that their reaction is valid. Despite the potential appeal of a “tidy” ending to the group with no loose ends remaining, facilitators can also recognize that such a wish does not reflect reality beyond the group, and that the “best” ending for the group is one that validates the varied and mixed reactions that accompany the final session.

In the service of guiding the group’s final meeting to a meaningful conclusion, facilitators can model a level of self-disclosure about what they wish to achieve for the last session. Facilitators can provide a scaffold for the final group meeting to help make the end of the group more manageable for its members. One way this can be achieved is by asking group members to consider the themes that have emerged out of the group’s work together. By the tenth session it is likely that the group has focused on particular topics, patterns, or issues that have held particular interest for the members. Facilitators (perhaps having done more consideration of this in advance of the final group) can offer their own interpretation of what themes have emerged, and how they have contributed to the development of the group. The goal is not necessarily to achieve a consensus within the group about what was “most” important, but rather to prompt discussion around what issues seemed to move the group forward or helped to increase cohesion

among the members. While the material presented by facilitators during the didactic component of the first eight groups helped to structure the group's interactions and focus, it is likely that the group (given its unique combination of individuals and presenting concerns) has developed its own understanding of how 9/11 impacted their lives.

Recognition of relational development within group.

Recognition of how individual relationships have developed and progressed throughout the group is a topic that will largely depend on how much the group has been able to tolerate and incorporate within-group processing of here-and-now behaviors and interactions. Facilitators should comment on relationships that seem to have been both supported and conflicted, and suggest that consideration of these relationships holds opportunities for interpersonal learning. Facilitators should not feel pressured to prompt or coerce a resolution between conflicted or opposing group members, but they can highlight that the continued participation and engagement of such members is indicative of a strength and resiliency that will continue to be of benefit beyond the end of the group. Facilitators can express their own observations about how the group has developed over time, including interactions or behaviors relating to the facilitators. As discussed previously, it is the facilitators' hope that the group has become less reliant and dependent on the facilitators for the group to function and has instead moved toward a position of recognizing the interdependency and support provided by the group as a whole.

In the final session, facilitators should welcome group members to reflect on their group experience and to discuss goals and/or hopes for their lives following the group. This may take a variety of forms for different group members, but facilitators can emphasize that this is the last opportunity for the group to share ideas and experiences. Facilitators can offer their own feedback or support for group members who choose to use the time to discuss what they hope to

achieve in the future, and in this way can model for other group members who wish to do the same. Facilitators can check in with the group as they notice the end of the group time approaching, and ensure that everyone who wishes to speak will be given time to do so. Facilitators may have to prompt the group to move on from one individual to another, and can also explain their desire to ensure that time is shared among group members.

Finally, the group facilitators can express their own goals for members of the group, and reflect that the ending of this group can hopefully be helpful in processing endings and transitions that occur in life. Group facilitators can end the group by expressing their appreciation for the work done by the group members as well as by sharing their own hopes that each individual will be able to carry their experience of the group with them into their lives. Facilitators can also recognize that although this is an end to the group in its current form and should be treated as such, that the work done by the members has likely revealed many common bonds and that everyone's continued participation in the WTC Health Program will help to anchor them in a larger community of resources and support.

Special Issues for Group Facilitators

As all group facilitators are privy to the topics and themes that the group curriculum seeks to introduce and address within the group over the course of ten short weeks, it may also go without saying that often even the most assertive attempts to move the group through the curriculum will likely be met with resistance or even turbulence. Facilitators have the added benefit of being able to hold a "long view" of psychotherapy by dint of their experience and training, which enables them to recognize the value of therapeutic interventions in response to the spontaneous and unplanned needs of the group and its members. While the purpose of this time-limited brief therapy group is ostensibly to provide a forum for 9/11 rescue and recovery

workers to share experiences with other members of the WTC health program while also incorporating relevant information about the effects of psychological stress and trauma, much of the group's potential value lies in the interactions between group members. With this aspect of the group in mind, facilitators initially hold a certain advantage in their approach to the group's activity. However, facilitators should also remain aware that this valuable aspect of the group (increased self-knowledge in the context of interpersonal communication) can occur at any point in the group's ten meetings. Facilitators should not feel pressured to sacrifice beneficial discussion of here-and-now phenomena in the service of dogmatic progression through the group curriculum. This is particularly important in the context of group and member safety as it relates to group sessions themselves. The stated value of facilitators' focus on complex or even upsetting individual behaviors or group processes also suggests that facilitators should be thusly equipped in the event particular situations arise.

Managing suicidality within group sessions.

Despite individual intake sessions and current engagement in individual outpatient mental health treatment, group facilitators should hold open the possibility that the experience of the group or the content that is discussed within it could be distressing or overwhelming to some members. In the event that a group member alludes to increased suicidal ideation or behaviors (such as telling the group that they have researched potential sites to complete suicide) group facilitators should explicitly state their roles in ensuring the safety of the group and its members. Group facilitators can explain that they are concerned about the group member's statements and that they imagine other members of the group may also feel concerned. The intent in such a statement is not to shame or embarrass a group member but to clearly convey concern and to demonstrate to the group that the facilitators are also aware of the seriousness of the statements.

During the group session, a facilitator may ask the group member if they would be willing to speak with a facilitator following the meeting. Provided they are able to agree to this, facilitators should also state that one of them is available to talk privately with the group member prior to the end of group if necessary or if the group member feels too overwhelmed to continue attending to the group for its remaining duration. The introduction of choice is intended to help promote autonomy and diminish any punitive or admonishing reactions to the group member's admission. In the event such a situation occurs for the first time within a group, facilitators also sending a message to the group about how they will respond should other group members express suicidal ideation or intent in the future.

Suicidal ideation should be treated seriously and openly acknowledged by facilitators during the group time, but a more thorough risk assessment should be reserved for a private meeting with the group member and a facilitator (either during the group time if the member so chooses or immediately following the conclusion of the group session). Regardless of when this assessment occurs, facilitators should be candid and decisive in stating their concerns and clinical impressions of the group member. While the management of suicidal risk may vary across different clinical sites and supervision hierarchies, there are several steps to ensure an ethical and clinically helpful encounter with a potentially suicidal group member. First, a facilitator can inform the group that they or their co-facilitator will be meeting with the group member individually to help address their needs. This will help to inform the group that the facilitators have a plan of action and hopefully help to alleviate some anxiety about danger to the group member in question. Additionally, it emphasizes the facilitator's responsibility to intervene in this situation, and allows the group (some of whom may themselves be accustomed to crisis scenarios) to understand that they are not expected to rescue their fellow group member.

Following a formal risk assessment, facilitators should establish a safety plan for the group member based on the outcome of their discussion. In most cases, a safety plan that consists of establishing a specific timeline for planned self-care and check-ins with facilitators, facilitator-initiated engagement with the group member's immediately available support system (e.g. emergency contact, spouse, or friend), and the notification of the group member's individual treatment provider will be an effective response to suicidal ideation. Facilitators and other supervisors should consider communication with the individual psychologist or psychiatrist essential and part of ethical care for their patient. Provided a strong therapeutic alliance has been established, the patient's individual provider will likely serve as an important ally for both facilitators and patients alike in such situations. If a group member is unable to consent or unwilling to agree to a plan or continues to endorse suicidal intent, group facilitators should clearly explain their ethical and legal obligation to ensure the safety of that group member and others. However, hospitalization or an accompanying call to police or security personnel should only be considered last-resort options. Group facilitators should also consider the practical benefit of such a decision, as hospitalizations may be limited in how well they address the patient's needs. Facilitators should emphasize their role as concerned collaborators who can access both a patient's distress at being alive and the patient's remaining engagement with vital internal and external resources.

Finally, suicidal ideation warrants a careful consideration of the greater context in which the thoughts and feelings have emerged and any decision made about the group member's continued participation in the group should occur in collaboration with the patient and their de facto treatment team. It should not be assumed that a member who experiences suicidal ideation within a group should then be deemed unsuitable for continuing in the group. In fact, regardless

of that group member's ability or willingness to return, the next session should allow for group reactions to the previous week's events. In this way facilitators can model continuity and cohesion, and demonstrate the understanding that one member's experience within the group can ultimately have a strong impact on all members of the group.

Managing hostility and aggression within group sessions.

In addition to the distress and anxiety that accompanies suicidality within the group, aggression and hostility directed toward other group members and toward the group facilitators can also impact the group's ability to complete its work. Here, hostility and aggression are meant to emphasize behaviors which seek to threaten, intimidate, or undermine others, either through the use of speech or overt physical behaviors. To the extent that a situation is something that can be handled within the therapeutic frame, group facilitators will likely "know it when they see it" regarding aggression that warrants outside intervention. For example, if a crime is committed or threats of physical violence are made toward another group member, facilitators and group members alike are obligated to notify authorities and seek help should such behaviors continue. However, it is much more likely that aggression and hostility will emerge in the form of arguments, comments, and passive aggressive behaviors toward members or facilitators.

Hostility between group members.

Hostility as it occurs between group members will likely, as with all other aspects of the group, depend on context. However, facilitators can use such opportunities to draw attention to a pattern of interaction that may reflect a parallel conflict within the group, or speak to similarities among group members in how they respond to their feelings or particular problems. Primarily, group facilitators want to observe the hostility and aggression as an interaction that is motivated by strong reactions and emotions. Facilitators' ability to recognize anger a useful indicator of an

individual's perception of a threat or injustice can serve to move a conflict between members into the more productive realm of discussion within the group. Facilitators can openly observe and draw the group's attention to the conflict in a way that does not "take sides" or seek to suppress or ignore the hostility as it occurs. Instead, facilitators can point out that in their experience when there is conflict between group members it typically signals that the group is progressing away from anxiety about joining the group and instead becoming more occupied with individual roles within the group. All group members should be encouraged to share their reactions of the conflict, one such intervention that differs from the usual social contract to "stay out of it". Instead, conflict between members presents an opportunity for the group to discuss itself, and is very much a "here and now" focus. While social mores in other settings usually discourage the direct expression of anger or conflict, the group's willingness to simply not "get along to go along" can be interpreted as a sign of group health and development. Facilitators also want to be mindful of their own "stake" in the conflict, such as in the instances of scapegoating wherein it is particularly important for facilitators to not align themselves with the aggressive or hostile parties but to again point out the aggression directed toward one member, as well as the possible significance of such a dynamic.

Hostility toward group facilitators.

Hostility and aggression directed toward group members is in some ways less complex to respond to, as facilitators will have more control over how they respond to a group member's aggression than they would in an instance of hostility between group members. Also, it is more likely that other group members may come to the defense of the facilitators in an effort to protect them from attacks. In reality, the group cannot exist without the facilitators- therefore attacks on the facilitators will likely be less tolerated by other members. However, facilitators should again

work to bring the conflict back into the general purview of the group. Whether the conflict stems from a group member's longstanding resentment of authority figures or their lifelong use of anger and disruptive behavior in order to have needs for security or attachment met are beyond the scope of this section, but such potential explanations may evolve throughout the group's work and lead to a greater amount of interpersonal learning.

Most importantly, group facilitators can demonstrate that they can not only withstand hostility from group members, but in fact are willing and accessible enough to attempt examination and even resolution of such matters within the group space. However such resolution plays out or manifests will (again) depend on the context of the initial conflict, but facilitators have an opportunity to transform an otherwise awkward or tense moment into one of significance and self-reflection. Throughout such a process, facilitators can find appropriate opportunities to commend a hostile group member for expressing negative feelings toward the facilitator on behalf of the group, as can often be the case. In the event of instances of aggression and hostility that remain within the group's collective window of tolerance, group facilitators should work as deliberately as possible to make the exploration of the conflict a group-wide exercise. Given the presence of anger and hostility in group members' lives as a potential response to traumatic stress and other exacerbating factors, it is important that a group atmosphere of understanding and acceptance be cultivated where possible, as this will yet further distinguish the group situation as a unique and distinct from everyday life.

Chapter VI: Proposed Evaluation of the Group Curriculum

Quantitative Analysis of Group Curriculum

Quantitative analysis is often useful in helping to identify potential relationships between specific categories within a research design. The group curriculum's use of categories and numerical outcome measures lend themselves intuitively to some degree of quantitative statistical analysis. Theoretically, quantitative methods are particularly useful and informative when dealing with large sample sizes and a specific intervention's generalizability is an area of interest. Because of the nature of the intended group size and the limits of recruiting large numbers of people from the overall population pool being studied, it is expected that quantitative methods alone may not provide the most comprehensive picture of the group curriculum's impact, which will be discussed later. For now, the focus will first remain on applying a quantitative statistical analysis to the group curriculum in order to determine if there is evidence in support of the hypothesis that the group curriculum can help provide a reduction in patient symptoms.

In order to examine the potential efficacy of the group curriculum as compared to a randomized control group that also met criteria for group inclusion, a mixed three-way analysis of variance (ANOVA) is proposed. This particular design will analyze data from two different time points (e.g. pre- and post- group intervention) for both the experimental group curriculum condition as well as the control treatment as usual (TAU) condition. Three separate analyses will be required for each outcome measure used, as the three measures are not validated for cross-comparison. As outlined in the methodology section, these quantitative outcome measures include the Trauma Symptom Checklist - 40 (TSC-40), the Posttraumatic Stress Disorder Checklist for DSM- IV (PCL), and the Outcome Questionnaire – 45 (OQ-45). The numerical

values generated by each self-report measure will serve as the dependent variable for this design, as each measure reliably assesses for various experiences of general distress, impact of traumatic experiences, and specific PTSD symptoms, albeit separately. The same mixed three-way ANOVA design is applicable to each outcome measure, respectively.

The mixed three-way ANOVA allows for analysis of data across the manipulation of three different independent variables and also provides information about interaction effects between different levels of each variable. The three different variables that are explored in this analysis are randomized group assignment (group curriculum vs. TAU), type of current individual treatment (psychotherapy vs. medication management vs. combination of therapy and medication), and finally, time (pre-group intervention vs. one week after the conclusion of the scheduled group time). To this extent, the mixed three-way ANOVA is suitable for a repeated-measures design with one between-group variable (group assignment) and one within-group variable (type of current individual treatment). It is worth noting that in this repeated measures design, the variable of time (pre and post group) is by definition a within-subjects variable. The result is a 2 x 2 x 3 ANOVA design, which is illustrated in Table 2.

Table 2

Visual Summary of Experimental Design Variables

IV 1: Randomized Group Condition	IV 2: Individual Treatment Type	IV 3 : Time	
		Pre-Group	1 wk. Post-Group
Group Curriculum Participants	1-on-1 Psychotherapy	Pt. A score 1	Pt. A score 2
	Medication Management	Pt. B score 1	Pt. B score 2
	Both Therapy & Medication	Pt. C score 1	Pt. C score 2
TAU only Participants	1-on-1 Psychotherapy	Pt. D score 1	Pt. D score 2
	Medication Management	Pt. E score 1	Pt. E score 2
	Both Therapy & Medication	Pt. F score 1	Pt. F score 2

As highlighted in Table 2, the dependent variable data (outcome measure scores) is gathered at two different times for each participant regardless of group assignment or individual treatment type. The mixed three way ANOVA will calculate and compare the variance of pre- and post- outcome scores for both group curriculum participants as well as control group participants. Because individual treatments are to remain constant throughout the research study, statistically significant differences between the variances in scores for each group can be attributed to an effect of the remaining independent variable, group condition. Such a difference could be considered evidence supporting the hypothesis that the group curriculum has an impact in reducing patients' report of distress and symptoms. However, while it can be said that such a statistically significant difference in scores (if found) suggests evidence in support of the group treatment's efficacy, it cannot be accurately stated that the difference in scores is definitively the result of an effective group treatment.

Examination of variable main effects.

In order to further determine the group treatment's potential efficacy, requested means of main effects for group condition status can demonstrate whether or not the assignment to the group or the TAU control group mattered. A test of main effects will compare score differences between group and non-group participation while assuming average levels of the two other independent variables (both time and independent treatment type). While this information can provide useful confirmation of a difference between the group therapy participants and the treatment as usual participants, it does not suggest any certainty that the group offers benefits in symptoms reduction for all participants. In order to see for whom the group may have had the largest impact, interaction effects must be observed.

Interaction effects between group variables.***Group status x individual treatment interaction.***

Provided that there is a significant statistical difference in pre- and post- group scores (and assuming that the change reflects a reduction in outcome measure scores), this difference would serve as supportive evidence that the group curriculum has some effect on reducing patients' symptoms. Additional information can be gleaned by examining the statistical output for potential significant interaction effects. For example, results may yield information suggesting that group members who were in psychotherapy had significantly different outcome measure scores than their fellow group members who were only receiving medication management from their psychotherapist. Comparisons across conditional groups can be made, such that the mean variance of outcome measure scores for individuals receiving individual psychotherapy while participating in the group curriculum can be compared to the outcome measure scores for individuals who received individual psychotherapy alone. As Table 2 suggests, many comparisons can be made across the various patient factors in order to estimate which combination of individual treatment (therapy, medication, or both) and group status (participation in the group curriculum or continued individual treatment as usual) are the most effective in reducing patient scores on the three different outcome measures.

Limitations of quantitative research design.

While the quantitative research design as it is suggested here is theoretically effective in parsing out the various effects of type of individual treatment, group status, and any difference in the combination of these two factors at two different points in time (pre- and post- group), the design relies on several key assumptions that potentially limit a quantitative analysis of the group curriculum.

One such assumption of this particular research design is that of adequate sample size. As mentioned at the start of this chapter, quantitative research is particularly useful when examining relationships between specific variables in large groups of people in order to gain an understanding of generalizability. However, adequate sample size is an inherent limiting factor in the ability to gain more reliable evidence of the group curriculum's potential efficacy (or lack of efficacy) in impacting patient symptoms. The current group curriculum calls for a group of six to nine group curriculum participants in addition to two group facilitators. Immediately this reveals that within the group condition, the sample size for evaluating a group is very small, and the issue of inadequate sample size is made even clearer in the context of examining different levels of individual treatment within the group condition. For example, random assignment to the group condition may yield a skewed proportion of individuals in one form of individual therapy than another, thus potentially confounding any observable impact of the group curriculum overall. Conversely, a larger control group with a different skew or more even distribution of waitlist participants across various types of individual treatments may affect the possibility for accurate comparisons across groups. While the mixed three-way ANOVA proposed here is theoretically more effective in accounting for different levels of individual treatment that are used concurrent to a participant's placement in a group curriculum condition or a waitlist control condition, in practice it may demand much larger sample sizes for each potential experimental and control condition in order to attain adequate power in detecting a significant result.

For example, a more straightforward one-way ANOVA could be used in order to detect a significant difference between the final (post-group only) outcome scores of the group curriculum members as compared to the waitlist control group irrespective of individual

treatment type and any baseline outcome measure score (the equivalent of pre-group scores on the three survey measures). In order for this simpler but less incisive design to have adequate power to detect a moderate statistical difference, the total amount of required participants in the study would be approximately 120 people, randomly assigned evenly to the group curriculum or the waitlist control. In the mixed three-way ANOVA, the required sample size quickly rises into the hundreds in order to detect the same effect within the various conditions outlined in Table 2. The one-way ANOVA could provide a comparison between two groups at a single point of time, but confounds would need to be more strictly controlled for or addressed in the research design.

Even within the mixed three-way ANOVA design discussed here, potential confounds exist that could affect the validity of any observed outcomes or evidence to support or refute the proposed efficacy of the group curriculum. For example, despite individual treatment being introduced as factor within this design, it should be noted that even among various levels of that condition, there is a lack of standardization and equivalence. For example, once a week supportive psychotherapy is conducted differently and has different therapeutic goals than a structured course of Cognitive Processing Therapy to address intrusive thoughts and experiences related to a particular traumatic event. However, within the current design they are both considered “individual psychotherapy” and are thus granted a (false) equivalence within the study. The same principle applies to different medications and the myriad potential combinations of individual psychotherapy and medication. Additionally, this research design does not account for how long an individual has been historically involved in different types of treatment, or the upper limit of someone’s duration of current individual treatment. As an example, someone who at first managed their symptoms with medication and then over the course of months was titrated off of medication by a psychiatrist and later referred for weekly

psychodynamic therapy two years prior to the study would only be considered a member of the psychotherapy only condition of the research design, irrespective of their previous experience in using medication management. Each additional attempt to account for these more specific within-condition differences would introduce additional complexity to the research design, and would simultaneously increase the need for participants in order to attain adequate statistical power to detect significant differences in outcomes.

An additional potential confound of the proposed research design involves the gathering of pre-group survey scores. Ideally, all of this data would be gathered at the same point of time under the same conditions for each individual to provide their subjective self-report of symptoms and experience under similar circumstances. However, the ability to ensure simultaneous timing and conditions for the gathering of pre-group data is very limited given the reality of the limits to accessing the population being studied. Because the work of recruiting participants for the research study may take weeks or months, pre-group survey scores may be occurring at different times of year and in different proximity to the eventual assignment to the group curriculum experimental group or the waitlist control group. Thus, the eventual difference or perceived impact of the eventual assigned condition may be impacted by however long a participant waited prior to the 11 week (10 weekly sessions plus a one week post-group follow-up) study duration.

Finally, given that the outcome measures used in the quantitative evaluation of the group curriculum all rely on self-report survey, there is the possibility of reporting bias inherent in conducting this kind of research. Participants who invested time and energy into the group or who are preoccupied with gaining approval from their former facilitators may report differently than individuals in the waitlist control group, albeit for reasons other than the actual effectiveness of the group curriculum which is the desired topic of study. However, the

specificity and value of an individual's subjective report around their experience of the group curriculum may be better captured through the use of qualitative research methods.

Qualitative Analysis of Group Curriculum

Qualitative research is useful to the evaluation of the group curriculum as it may be more effective in capturing the complexity of individual group members' experience in the group to a greater and more nuanced degree than any of the suggested outcome measures. Qualitative research is often used in order to facilitate exploration of a topic or idea, particularly when existing research may be limited or there are particular challenges to the types of research questions being asked. The group curriculum lends itself well to a qualitative approach because of the assumption that the sample size will be quite small, thus obfuscating the extent to which statistical quantitative findings are both accurate and generalizable. However, qualitative research can help to provide a better understanding of how the group curriculum has affected the members in their own words and with the freedom to provide additional information that would go unrecorded or unobserved through the use of quantitative methods alone.

One way of gathering qualitative data from participants in the group curriculum is through the use of scheduled post-group interviews conducted by a group facilitator. While the use of a facilitator may be less ideal than an unaffiliated third party interviewer, the potential logistical necessity of facilitator involvement to leverage and retain group member participation in the last phase of the study may be likely. The group facilitator, through the process of rapport building and familiarity with the individuals in the group, may have an advantage over a more naïve interviewer in eliciting more substantive and personal responses. Examples of qualitative interview questions that will be asked of all group members are as follows:

What does the patient think he/she has gained by attending the group? Can they provide any examples or specific situations?

What does the patient think he/she has contributed to the group? Can they provide any examples or specific situations?

Has the patient noticed any recent changes in difficulties related to their social functioning (relationships with friends, family, spouse, partner, coworkers)? What has changed about these difficulties? Please provide any examples or specific situations that may be relevant.

Has the patient noticed any recent changes in difficulties related to their physical functioning (general health, sleep, fatigue, ability to rest or relax)? What has changed about these difficulties? Please provide any examples or specific situations that may be relevant.

Has the patient noticed any recent changes in difficulties related to their occupational functioning or ability to be productive? What has changed about these difficulties? Please provide any examples or specific situations that may be relevant.

Is there anything new you learned about how your experience of 9/11 has impacted your quality of life since attending the group? Is there anything new you learned about how to manage any of the difficulties we just talked about? Please provide any examples or specific situations that may be relevant.

Would you recommend this group to a friend or colleague who was involved in the 9/11 rescue/recovery/cleanup effort? What would you say to them?

What do you think it would be like to continue meeting with your current group? What would be attractive to you about that idea? What do you think would be unpleasant or unhelpful about that idea?

Each of these questions seeks to move beyond the realm of data that can be captured through the use of specific outcome measures. Instead, the focus of these items is on a group member's own relationship to their experience of the group curriculum. Whereas the quantitative measures seek to assess changes in symptoms and then infer the group's potential efficacy based on said changes, the qualitative methods reflected in the above questions ask directly about the group itself. By recording and considering the content of group member's responses, more specific information about what the group was able to provide for group members may emerge. This could be particularly compelling in the event that quantitative

analysis does not yield any evidence in support of the group curriculum's effectiveness in reducing symptoms, but group members experience the group positively regardless.

Explanations for such a phenomenon may fall outside the scope of the quantitative methods used to research the group curriculum, but more applied qualitative methods could provide alternative research questions or suggest ways in which the group curriculum could be adapted in order to further meet the subjective and fluid demands of the group members themselves. In many ways, qualitative research methods may provide focused information about ways the group curriculum could be improved or changed based on the testimony of members who have experienced it. This is quite different from the quantitative analysis, which even if empirically sound would not provide additional information about which aspect(s) of the group curriculum were of potential benefit or not.

Finally, the content of the responses yielded by qualitative data gathered via interviews can be examined in the context of Yalom's therapeutic factors, which are unique but not necessarily wholly exclusive to group treatment. Yalom's therapeutic factors provide a helpful framework to see where in the experience of the group curriculum various group members' responses "map onto" one or more helpful or beneficial aspects of the group curriculum. A summary of Yalom's therapeutic factors is presented in Table 3. Each therapeutic factor lends itself to qualitative exploration and potential individual relevance. As there is no reliable or valid quantitative measure or instrument that assesses "corrective recapitulation of primary family experience" within any treatment, patient's responses to interview questions may suggest that such a process took place for them during different parts of the group. Qualitative data ultimately serves to help inform the facilitators' impressions about the group's meaning and

benefit to the group members, and when used in combination with available quantitative data provides a wider and deeper perspective of the group curriculum's potential value.

Table 3

Summary of Yalom's Therapeutic Factors (Adapted from 2007 AGPA Guidelines)

Therapeutic Factor	Definition
Universality	Members recognize that other members share similar feelings, thoughts and problems
Altruism	Members gain a boost to self-concept through extending help to other group members
Instillation of hope	Member recognizes that other members' success can be helpful and they develop optimism for improvement
Imparting information	Education or advice provided by the therapist or group members
Corrective recapitulation of primary family experience	Opportunity to reenact critical family dynamics with group members in a corrective manner
Development of socializing techniques	The group provides members with an environment that fosters adaptive and effective communication
Imitative behavior	Members expand their personal knowledge and skills through the observation of group members' self-exploration
Cohesiveness	Feelings of trust, belonging and togetherness experienced by the group members
Existential factors	Members accept responsibility for life decisions
Catharsis	Members release of strong feelings about past or present experiences
Interpersonal learning- input	Members gain personal insight about their interpersonal impact through feedback provided from other members
Interpersonal learning- output	Members provide an environment that allows members to interact in a more adaptive manner
Self-understanding	Members gain insight into psychological motivation underlying behavior and emotional reactions

In observing the various therapeutic factors presented in Table 3, various post-group responses may appear related to one or more of these factors, suggesting areas where the group offers some benefit or value that is not fully captured through quantitative analysis but has been deemed helpful nonetheless.

Chapter VII: Discussion

The development of a group curriculum and a proposed method for its evaluation is in several ways a response to recent trends in current clinical therapeutic practice. As discussed in earlier sections of this paper, the group curriculum seeks to achieve a balance between the assumed utility of easily-disseminated and broadly applicable treatment manuals and the assumed value of more individualized and context-specific treatment approaches. This dichotomy, which has emerged more generally in reference to both theoretical orientations (for example, Cognitive Behavior Therapy vs. psychoanalytic or psychodynamic therapy) as well as modes of delivery (group therapy vs. individual therapy) has resulted in more limited opportunities for the understanding of psychological phenomena for both practitioners and patients alike.

The philosophical goal of the group curriculum as it has been presented here is to bridge the pragmatic and the dynamic- to simultaneously consider the need for the implementation of an accessible and effective treatment while aspiring to provide a flexibility that enables responsiveness to the differentiated needs of individual clinicians and patients. Such a goal is not meant to suggest that any one theoretical approach or treatment model entirely lacks pragmatism or adaptability. Indeed, there is inherent pragmatism in adaptability, but often researchers and clinicians are presented with a narrow menu of available modalities that may sacrifice one for the other, albeit with neither specific necessity nor motive.

The desirability and advantages of treatments that have withstood a particular level of academic, scientific, and clinical rigor to the extent that they can be deemed “empirically validated” is both understandable and admirable. However, it may often be the case that such evidence-based approaches unwittingly exclude complementary but different theoretical

techniques or approaches in the service of parsimony. Unfortunately the result has been to further isolate one theoretical approach from another, through both the production of manualized treatments intended for a lay audience or esoteric formulations that defy the strictures of empirical measurement. Instead, the group curriculum seeks to occupy the space between- to provide an integrated treatment that is grounded in the logistics of conducting therapy in the real world amidst a continually evolving knowledge base concerning the psychological impact of traumatic experiences.

As more symptom-focused and disorder-focused treatments become available, the group curriculum serves as an effort to offer an experience-focused treatment that accommodates the individuals participating in the treatment while being just portable and structured enough to provide similar benefit in a different setting or with different individual participants. Group therapy treatments in particular have been notoriously understudied for the very same set of complications that also make them beneficial for so many- the truth is that no two groups are the same.

In a field that aims to increase the reliability and validity of its interventions as a means of justifying itself to various political and economic interests, group therapy as a replicable means of treatment holds a certain degree of risk and ambiguity. Certain exceptions to this have evolved, such as group adaptations to Cognitive Processing Therapy or CBT-based groups that focus on psychoeducation or the development of specific social skills. However, groups modeled after Yalom's interpersonal process groups go largely unevaluated, likely because of the incredible amounts of moving parts and potentially confounding variables embedded in the group milieu itself. Despite the research challenges presented by some approaches and the admittedly daunting nature of finding effective scientific ways to evaluate successful group

treatments which can then be consistently recreated with entirely different personnel, these complexities should not totally discourage efforts to advance focused treatments that incorporate components from different origin sources. Rather, the relatively burgeoning state of psychological science suggests areas of tremendous opportunity and potential for growth. The group curriculum represents an effort to move away from an “either/or” approach to treating trauma within a specific population and a step toward a “yes, and” integration of available techniques and modalities.

While perhaps easily dismissible as “eclectic”, theoretically agnostic, or impractical for convenient empirical study, the group curriculum serves as an attempt to map a small part of a largely uncharted territory- group treatments that serve a specific population. In this sense, the group curriculum and its potential usefulness to 9/11 rescue and recovery workers is not intended to be generalizable across all people, but rather is tailored to the assumed needs and interests of these particular men and women. Despite the specificity of this intent, there remains considerable value in developing treatments that can be both evaluated and reproduced without sacrificing a guiding framework and certain core theoretical elements.

Appendix A

Informed Consent for Group Intervention Research Study
For World Trade Center Rescue & Recovery Personnel

Description

This study is interested in researching the potential effects of a time-limited group therapy experience on the distress experienced by some rescue and recovery workers who were involved in the aftermath of the 9/11 attacks. The potential participants in this study are all registered program members of the WTC health program, just as you are. This research study is interested in the effects of a 10-week program of talk therapy led by two co-facilitators who have received special training in group therapy. You will not be asked to take any medications, or to provide any physical samples for this research. Conversely, you will not be asked to discontinue or otherwise disclose any current individual treatment (therapy, medication, or otherwise) that you are receiving for a medical or mental health issue. All participants are encouraged to discuss their current treatment status and concerns with us prior to agreeing to participate in our study.

Attendance

Your presence in group is highly important. A group dynamic is formed that helps create an environment for growth and change. If you are absent from the group this dynamic suffers and affects the experience of you and other members of the group. Therefore, your facilitator(s) ask that you make this commitment a top priority for the duration of the group. It is understood that occasionally an emergency may occur that will prevent you from attending group. If you are faced with an emergency or sudden illness, please contact your facilitator(s) before group begins let them know you will not be present.

We ask all participating members to make a 10-week commitment to this time-limited group therapy experience. **We ask this because each member of a group is important--your presence and your absence impacts both members and facilitators.**

By participating in this group and responding both to the pre-group interview and post-group interview, you are providing valuable feedback that can help to inform the treatment of other 9/11 rescue, recovery, and cleanup personnel. Your feedback is only valid if you are able to attend the 10-week group regularly, and any persistent issues with attendance will be addressed with a group facilitator and may impact your further participation in this group.

Expectations

Group time consists of a presentation component followed by processing/discussion time. Processing may revolve around an issue one member of the group is working on with time for feedback and

reactions by other members of the group, or a more general exploration of the theme that is introduced during the presentation component. At times the group may focus on a topic with all members verbally participating. In either case, the group dynamic offers a place where you can experience support, give support, and understand more clearly how you relate to others, as well as gain clarification of your current experience as it may relate to the events of September 11, 2001. Group time will take approximately 100 minutes (1 hour, 40 minutes) per week for 10 consecutive weeks. Pre-group and Post-group interviews and questionnaires will require one individual meeting with a group facilitator for approximately one hour each meeting.

Potential Risks

As you might imagine, many individuals experiencing distress as a result of their experience of 9/11 may not be used to discussing their role in the rescue & recovery effort, and also may not be aware of their potential reactions to hearing others discuss their own experiences. Because of this, it should be made clear that there is some risk of emotional distress and discomfort related to the difficulties that this group is intending to study and address. If at any time you find your experience within the group to be intolerable, please notify one of your group facilitators immediately. Every ethical effort will be made by your group facilitators to ensure that the group is a place of confidentiality, safety, and respect for the individuals present.

Research Data

By participating in this study, you will be asked to fill out several questionnaires about your personal and emotional experiences. This data and your responses will be kept strictly confidential and anonymous. Your responses to these questionnaires will not be attached to your name, nor will your name be used in any form in any future publication or writings. This information is to be kept separate from your Private Health Information (PHI) which is discussed later in this document. Your responses to these questionnaires and interviews will be included as data in any future publications, writings, or presentations that come as a result of the findings of this study. However, in all such instances your response data will be kept anonymous and used only for research purposes. Each group participant will be given a participant ID number upon entering the study, which will be used to keep your data in an anonymous file on the grounds of the World Trade Center health program where you are attending group. Only the group facilitators and relevant research personnel (Program Director, Supervising Staff) will have access to your questionnaires and responses. No unauthorized research personnel will have access to your Electronic Medical Record kept by the World trade Center health program for any conditions that you are currently receiving treatment. Group facilitators and supervisory staff will make necessary documentation (e.g. brief group therapy notes, documentation of attendance) to your medical file as deemed ethical and required by law.

Clarification of Voluntary Participation: *You do not have to take part in this research if you do not wish to do so and refusing to participate will not affect your current or future treatment at this clinic in any way. You will still have all the benefits that you would otherwise have at this clinic. You may stop participating in the research at any time that you wish without losing any of your rights as a patient here. Your treatment at this clinic will not be affected in any way.*

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this research.

Patient Signature

Date

Mental Health Clinician Signature

Date

Notice Policies and Practices to Protect the Privacy of Your Health Information

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the New Jersey Division of Youth and Family Services.
- **Adult and Domestic Abuse:** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.
- **Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.
- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.
- **When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law:** This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI*: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologists' Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send this information by mail.

V. Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact [Facilitator Name, WTC CCE Contact & Address].

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to [Facilitator Name, WTC CCE Contact & Address].

You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 1, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail.

Patient Signature

Date

Mental Health Clinician Signature

Date

Appendix B

TSC-40 for WTC Group Research Study

PRE / POST (Clinician Circle one)

DATE _____

ID # _____

FACILITATOR NAME _____

How often have you experienced each of the following in the last two months?

0 = Never 3 = Often

- | | |
|--|---------|
| 1. Headaches | 0 1 2 3 |
| 2. Insomnia (trouble getting to sleep) | 0 1 2 3 |
| 3. Weight loss (without dieting) | 0 1 2 3 |
| 4. Stomach problems | 0 1 2 3 |
| 5. Sexual problems | 0 1 2 3 |
| 6. Feeling isolated from others | 0 1 2 3 |
| 7. "Flashbacks" (sudden, vivid, distracting memories) | 0 1 2 3 |
| 8. Restless sleep | 0 1 2 3 |
| 9. Low sex drive | 0 1 2 3 |
| 10. Anxiety attacks | 0 1 2 3 |
| 11. Sexual overactivity | 0 1 2 3 |
| 12. Loneliness | 0 1 2 3 |
| 13. Nightmares | 0 1 2 3 |
| 14. "Spacing out" (going away in your mind) | 0 1 2 3 |
| 15. Sadness | 0 1 2 3 |
| 16. Dizziness | 0 1 2 3 |
| 17. Not feeling satisfied with your sex life | 0 1 2 3 |
| 18. Trouble controlling your temper | 0 1 2 3 |
| 19. Waking up early in the morning and can't get back to sleep | 0 1 2 3 |

20. Uncontrollable crying	0 1 2 3
21. Fear of men	0 1 2 3
22. Not feeling rested in the morning	0 1 2 3
23. Having sex that you didn't enjoy	0 1 2 3
24. Trouble getting along with others	0 1 2 3
25. Memory problems	0 1 2 3
26. Desire to physically hurt yourself	0 1 2 3
27. Fear of women	0 1 2 3
28. Waking up in the middle of the night	0 1 2 3
29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3

PCL for WTC Group Research Study

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem **IN THE PAST MONTH**. Please fill in ONE option only for each question.

	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2.	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
3.	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6.	Avoid <i>thinking about</i> or <i>talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities</i> or <i>situations</i> because <i>they remind you</i> of a stressful experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant</i> or <i>cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					

12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling</i> or <i>staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

PRE / POST (Clinician Circle one)

DATE _____

ID # _____

FACILITATOR NAME _____

--

OQ – 45 for WTC Group Research Study

PRE / POST (Clinician Circle one)

DATE _____

ID # _____

FACILITATOR NAME _____

Never
Rarely
Sometimes
Frequently
Almost Always

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and circle the number which best describes your current situation. Circle only one number for each question and do not skip any. If you want to change an answer, please “x” it out and circle the correct one.

- | | | | | | |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 1. I get along well with others. |
| 0 | 1 | 2 | 3 | 4 | 2. I tire quickly. |
| 0 | 1 | 2 | 3 | 4 | 3. I feel no interest in things. |
| 0 | 1 | 2 | 3 | 4 | 4. I feel stressed at work/school. |
| 0 | 1 | 2 | 3 | 4 | 5. I blame myself for things. |
| 0 | 1 | 2 | 3 | 4 | 6. I feel irritated. |
| 0 | 1 | 2 | 3 | 4 | 7. I feel unhappy in my marriage/significant relationship. |
| 0 | 1 | 2 | 3 | 4 | 8. I have thoughts of ending my life. |
| 0 | 1 | 2 | 3 | 4 | 9. I feel weak. |
| 0 | 1 | 2 | 3 | 4 | 10. I feel fearful. |
| 0 | 1 | 2 | 3 | 4 | 11. After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark “never”). |
| 0 | 1 | 2 | 3 | 4 | 12. I find my work/school satisfying. |
| 0 | 1 | 2 | 3 | 4 | 13. I am a happy person. |
| 0 | 1 | 2 | 3 | 4 | 14. I work/study too much. |
| 0 | 1 | 2 | 3 | 4 | 15. I feel worthless. |
| 0 | 1 | 2 | 3 | 4 | 16. I am concerned about family troubles. |

- 0 1 2 3 4 17. I have an unfulfilling sex life.
- 0 1 2 3 4 18. I feel lonely.
- 0 1 2 3 4 19. I have frequent arguments.
- 0 1 2 3 4 20. I feel loved and wanted.
- 0 1 2 3 4 21. I enjoy my spare time.
- 0 1 2 3 4 22. I have difficulty concentrating.
- 0 1 2 3 4 23. I feel hopeless about the future.
- 0 1 2 3 4 24. I like myself.
- 0 1 2 3 4 25. Disturbing thoughts come into my mind that I cannot get rid of.
- 0 1 2 3 4 26. I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark "never").
- 0 1 2 3 4 27. I have an upset stomach.
- 0 1 2 3 4 28. I am not working/studying as well as I used to.
- 0 1 2 3 4 29. My heart pounds too much.
- 0 1 2 3 4 30. I have trouble getting along with friends and close acquaintances.
- 0 1 2 3 4 31. I am satisfied with my life.
- 0 1 2 3 4 32. I have trouble at work/school because of my drinking or drug use (if not applicable, mark "never").
- 0 1 2 3 4 33. I feel that something bad is going to happen.
- 0 1 2 3 4 34. I have sore muscles.
- 0 1 2 3 4 35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
- 0 1 2 3 4 36. I feel nervous.
- 0 1 2 3 4 37. I feel my love relationships are full and complete.
- 0 1 2 3 4 38. I feel that I am not doing well at work/school.
- 0 1 2 3 4 39. I have too many disagreements at work/school.
- 0 1 2 3 4 40. I feel something is wrong with my mind.
- 0 1 2 3 4 41. I have trouble falling asleep or staying asleep.
- 0 1 2 3 4 42. I feel blue.
- 0 1 2 3 4 43. I am satisfied with my relationships with others.
- 0 1 2 3 4 44. I feel angry enough at work/school to do something I might regret.
- 0 1 2 3 4 45. I have headaches.

WTC Group Research Study

Brief Screening Questionnaire

Name:

County/State of Residence:

In order to ensure that the services we provide meet the standards of those we serve, we would like to know about your experiences engaging in mental health services through the WTC Health Program.

Please answer these questions to the best of your ability. Though your participation in this survey is optional, we encourage your feedback as it will be helpful to us in providing a better service. We thank you again for your feedback.

1. In any of your visits to the WTC Health Program, have you met with a mental health clinician?

YES

NO

NOT SURE

2. Did this mental health clinician refer you to one of our external community providers for psychotherapy or medication?

YES

NO

N/A

3. Have you been diagnosed with a psychological disorder at any time after the 9/11 attacks?

YES

NO

NOT SURE

If so, write the diagnosis here: _____

4. We would like to know more about your mental health treatment history. To the best of your ability, complete the form below, starting with the name of your mental health provider. This would include any of the mental health clinicians seen through the WTC Health Program and any other therapist(s), psychologist(s), and/or psychiatrist(s) you may have seen AFTER 9/11 as a result of your involvement in the WTC rescue and recovery.

Name of provider (try your best to remember) and practice (therapy and/or medication?)	When did you start meeting with this provider?	Have you ended your treatment with this provider? If so, when?	Did you find treatment helpful? (Y/N?)

5. Have you been diagnosed with a medical illness or physical disorder any time after the 9/11 attack?

YES

NO

NOT SURE

If so, which disorder (s): _____

6. Do you feel as though you are currently experiencing difficulty in your social functioning (relationships with friends, family, spouse, partner, coworkers) as a result of (or related to) your role in the 9/11 rescue, recovery, or cleanup?

YES

NO

NOT SURE

If yes or not sure, please specify: _____

7. Do you feel as though you are currently experiencing difficulty in your physical functioning (general health, sleep, fatigue, ability to rest or relax) as a result of (or related to) your role in the 9/11 rescue, recovery, or cleanup?

YES

NO

NOT SURE

If yes or not sure, please specify: _____

8. Do you feel as though you are currently experiencing difficulty in your occupational functioning or ability to be productive as a result of (or related to) your role in the 9/11 rescue, recovery, or cleanup?

YES

NO

NOT SURE

If yes or not sure, please specify: _____

9. Would you allow a clinician from the WTC Health Program, NJ to follow up with you regarding possible participation in a confidential, no-cost research study?

YES

NO

Group Intake for WTC Group Research Study

DATE _____

ID # _____

FACILITATOR NAME _____

Information about the pt.'s experience in 9/11

What were the responder's responsibilities, and for which union/organization did they work? Do they view their experiences negatively, positively, and why? Document the patient's associations to 9/11 and the rescue/recovery/cleanup effort.

Does s/he find it helpful to talk to others about their experiences? If they are comfortable talking with specific persons, who?

Patient's Psychiatric History

Which symptoms, if any, does the patient report as a result of 9/11?

How were the patient's relationships (family, friends, co-workers) affected as a result of 9/11?

Does the patient have a psychiatric history unrelated to 9/11? How did his or her involvement after 9/11 affect it?

Patient's Medical History

Does the patient have any medical conditions related to 9/11? Any medical conditions before 9/11?

How has the pt. coped with these medical conditions?

Has the patient felt supported by others throughout the treatment process? What are some specific sources of support that you have received?

Patient's Interpersonal Group Dynamics

What does the patient think he/she can get out of the group? Out of continuing current treatment?

What does the patient think he/she can contribute to the group?

What concerns does the patient have about the possibility of joining a group to discuss difficulties related to 9/11?
Any concerns about continuing current treatment?

Post-Group Interview for WTC Group Research Study

DATE _____

ID # _____

FACILITATOR NAME _____

Part A: for Group Participants and TAU Control Participants

Information about the pt.'s experience in 9/11

Does the patient currently view their experience of the 9/11 rescue/recovery/cleanup effort negatively, positively, and why? Document the patient's associations to 9/11 and the rescue/recovery/cleanup effort.

Has s/he found it any easier to talk to others about their experiences?

Patient's Psychiatric History

Which symptoms, if any, does the patient currently report as a result of 9/11?

How were the patient's relationships (family, friends, co-workers) affected as a result of 9/11?

Does the patient have a psychiatric history unrelated to 9/11? How did his or her involvement after 9/11 affect it?

Patient's Medical History

Does the patient have any medical conditions related to 9/11? Any medical conditions before 9/11?

How has the pt. coped with these medical conditions?

Has the patient felt supported by others throughout the treatment process? What are some specific sources of support that you have received?

Part B: for Group Participants ONLY

What does the patient think he/she has gained by attending the group? Can they provide any examples or specific situations?

What does the patient think he/she has contributed to the group? Can they provide any examples or specific situations?

Has the patient noticed any recent changes in difficulties related to their social functioning (relationships with friends, family, spouse, partner, coworkers)? What has changed about these difficulties? Please provide any examples or specific situations that may be relevant.

Has the patient noticed any recent changes in difficulties related to their physical functioning (general health, sleep, fatigue, ability to rest or relax)? What has changed about these difficulties? Please provide any examples or specific situations that may be relevant.

Has the patient noticed any recent changes in difficulties related to their occupational functioning or ability to be productive? What has changed about these difficulties? Please provide any examples or specific situations that may be relevant.

Is there anything new you learned about how your experience of 9/11 has impacted your quality of life since attending the group? Is there anything new you learned about how to manage any of the difficulties we just talked about? Please provide any examples or specific situations that may be relevant.

Would you recommend this group to a friend or colleague who was involved in the 9/11 rescue/recovery/cleanup effort? What would you say to them?

What do you think it would be like to continue meeting with your current group? What would be attractive to you about that idea? What do you think would be unpleasant or unhelpful about that idea?

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