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The Grief Industry: How much does crisis counseling help-or hurt?

by Jerome Groopman January 26, 2004

Soon after the collapse of the World Trade Center, experts predicted that one out of five New Yorkers—some one and a half million people—would be traumatized by the tragedy and require psychological care. Within weeks, several thousand grief and crisis counsellors arrived in the city. Some were dispatched by charitable and religious organizations; many others worked for private companies that provide services to businesses following catastrophes.

In the United States, grief and crisis counsellors generally use a method called critical-incident stress debriefing, which was created, in 1974, by Jeffrey T. Mitchell, a Maryland paramedic who was studying for a master's degree in psychology. Mitchell had seen a gruesome accident while on the job: a young bride, still in her wedding dress, had been impaled when the car that her drunk husband was driving rear-ended a pickup truck loaded with pipes. He was unable to shake the memory. Six months later, he confided his troubles to a friend—a firefighter who had witnessed similar horrors. The friend asked him to describe exactly what he had seen. Mitchell felt greatly relieved by this conversation, and became convinced that he had stumbled across an invaluable therapeutic approach. Indeed, he came to think that if a "debriefing" conversation was held soon after an upsetting event it could help prevent the onset of post-traumatic stress disorder.

In 1983, Mitchell received a Ph.D. in human development, and he began crafting a structured seven-step debriefing regimen that could be applied to groups of paramedics, firefighters, and other professionals who regularly witnessed traumatic events. Six years later, he started a nonprofit organization, the International Critical Incident Stress Foundation, to teach debriefing and related methods. The foundation has grown steadily, and more than thirty thousand counsellors are trained by it each year.

In a typical debriefing session, crisis counsellors introduce themselves and provide basic information about common stress reactions—sleeplessness, headache, irritability—as well as more debilitating symptoms, like flashbacks and delusions. Each participant is then asked to identify himself, pinpoint where he was during the tragic event (or "critical incident"), and describe what he witnessed. This is known as the "fact phase." The discussion next turns in a more emotional direction, as each participant is asked to divulge what he was thinking during the event. The purpose of sharing such memories is, in part, to draw out group members who "bottle up" their emotions. At the end of this process, the conversation enters the "feeling phase," focussing on each participant's current reaction to the catastrophe. (The counsellors ask questions like "What was the worst part of the incident for you personally?") Finally, the counsellors discuss strategies for coping with stress and suggest services that can provide additional help; by the end of the session, participants are considered ready for "reëntry" into the world. The group does not meet for a follow-up session.

I recently spoke with a man who worked at a travel agency on Liberty Street, across from where the Twin Towers once stood. He had been in the subway when the towers collapsed, but after considerable difficulty he made it home safely. “I was called by the company the next day and told to report to headquarters on Thursday,” he told me. His parent corporation, which was situated in midtown, and had numerous offices throughout the city, had hired an organization called National Employee Assistance Providers to give debriefing sessions. Many of its counsellors used texts created by Mitchell’s foundation during their training.

Most debriefings occur between twelve and seventy-two hours after a catastrophe, according to “Blindsided: A Manager’s Guide to Catastrophic Incidents in the Workplace,” by Bruce T. Blythe, the C.E.O. of Crisis Management International, a company that offers psychological services. Blythe writes, “Earlier than that, people are likely too numbed to put their personal reactions into words; after seventy-two hours, people typically begin to ‘seal over’ emotionally.” This “sealing over” is seen as dangerously “laying the ground” for P.T.S.D. In most circumstances, employees are required to attend a debriefing session. Blythe writes, “Experience has shown that if attendance is voluntary, those most in need of support will not come, out of fear or discomfort.”

The travel agent sat in a conference room with co-workers from the Liberty Street branch who had witnessed the collapse of the World Trade Center and had been evacuated from the building. Also attending the session were employees from uptown offices who had not witnessed the collapse or been at risk. In all, there were between twenty and thirty participants at this debriefing session. “There were two counsellors, a man and a woman, and they encouraged us to tell our stories and vent our feelings,” the travel agent told me.

When it was the agent’s turn, he revealed to the group that, at the time of the attacks, he had been sitting in a subway car, just short of the Fulton Street station. The train came to an abrupt halt, the air-conditioning went off, and the conductor announced that the train’s doors were stuck. Passengers managed to pry open the doors; as they stepped onto the platform, a tremendous blast of black smoke filled the air. It blew a woman walking in front of the agent off her feet. He ran away from the billowing smoke, and soon found himself pressed up against a turnstile exit that wouldn’t budge. The crowd pushed behind him, and he began to struggle for air. (“I said to myself, ‘I’m not dying here,’ ” he told the group.) He broke free of the mob and found a stairwell; when he arrived at street level, the air was so dark with soot that he still felt as if he were trapped underground. He walked north and eventually got home.

“I told what happened to me, and people started crying,” he recalled. A colleague said she had made her way to the pier where she usually catches a ferry to her home in New Jersey. “She told everyone how she came across a dazed co-worker walking aimlessly in the darkness, and how they both saw people jumping into the water even though there was no boat there,” he said. Another employee from the Liberty Street branch spoke vividly about watching bodies fall from the towers.

I asked the agent whether he had chosen to attend the debriefing. “Well, they felt everyone should participate,” he said. When he was asked if it had been helpful, he shrugged and said that, like most of his Liberty Street colleagues, he was relatively numb during the debriefing. “Some people burst into tears,” he said. “But the people who were really crying hadn’t even been downtown.”

At the end of the session, the two counsellors gave telephone numbers to the workers and encouraged them to call if they felt distressed. The travel agent had nightmares for weeks after the debriefing, and often felt as if he were choking. Images similar to the ones he had described during the session would flash through his mind. He didn’t pursue further therapy, though. “I had to take care of my family; they rely on me,” he explained. After several months, he said, the flashbacks and the sense of choking subsided. “You just block it out,” he said. “You have to get on with life.”

The director of human resources at the travel agent’s company told me that she had arranged the debriefing session because “it made me feel that I was doing something for the employees.” She went on, “I saw behavior that worried me, people very upset after the attacks. I didn’t want the company to seem unfeeling.” Another concern that leads companies to hire debriefing services is the fear of litigation. Employees who have experienced a traumatic incident on the job, and who have subsequently been sidelined by P.T.S.D., have sued their companies. The Web site for National Employee Assistance Providers claims that its debriefing program insures “that the productivity of the work unit is not impaired.”

Hundreds of similar debriefing sessions took place in Manhattan in the days following the September 11th attacks. Did they help? One debriefing company told me that 99.7 per cent of the participants found the sessions beneficial. But such evaluations are subjective, and hardly scientific. In fact, only in the past few years has debriefing undergone serious scrutiny. Brett Litz, a research psychologist at Boston Veterans Affairs Medical Center who specializes in post-traumatic stress disorder, recently completed a randomized clinical trial of group debriefing of soldiers who were stationed in Kosovo. (Peacekeeping forces there were exposed to sniper fire and mine explosions, and discovered mass graves.) He summarized the academic verdict on debriefing as follows: “The techniques practiced by most American grief counsellors to prevent P.T.S.D. are inert.”

Clinical trials of individual psychological debriefings versus no intervention after a major trauma, such as a fire or a motor-vehicle accident, have had discouraging results. Some researchers have claimed that debriefing can actually impede recovery. One study of burn victims, for example, found that patients who received debriefing were much more likely to report P.T.S.D. symptoms than patients in a control group. It may be that debriefing, by encouraging patients to open their wounds at a vulnerable moment, augments distress rather than lessens it.

Mitchell, the movement's founder, told me that debriefing has been "distorted and misapplied" by some private companies, and noted that some negative findings stem from studies of these unorthodox variants. His technique, he added, is meant only for "homogeneous groups who have had the same exposure to the same traumatic event," and sometimes crisis counsellors brought together people who had experienced unrelated traumas. With firefighters who had, say, all watched one of their colleagues die, Mitchell said that his method had a "proven" beneficial effect. He could cite no rigorous clinical trials, however, in support of this claim.

Scientific studies suggest that, after a catastrophic event, most people are resilient and will recover spontaneously over time. A small percentage of individuals do not rebound, however, and require extended psychological care. The single intervention of a debriefing session does nothing to alter this consistent dynamic.

Despite the influx of counsellors into Manhattan, most New Yorkers received no therapy following the attacks. Furthermore, data from surveys taken after September 11th contradicted the early predictions that there would be widespread psychological damage. A telephone survey of nine hundred and eighty-eight adults living below 110th Street, conducted in October and November of 2001, found that only 7.5 per cent had been diagnosed as having P.T.S.D. (According to the American Psychiatric Association, a patient is said to have P.T.S.D. if, for a month or more after a tragic event, he experiences several of the classic symptoms: flashbacks, intrusive thoughts, and nightmares; avoidance of activities and places that are reminiscent of the trauma; emotional numbness; chronic insomnia.) A follow-up of this survey, in March of 2002, found that only 1.7 per cent of New Yorkers suffered from prolonged P.T.S.D. This finding indicates that the debriefing industry is predicated on a false notion: that we are all at high risk for P.T.S.D. after exposure to a traumatic event.

In the wake of a catastrophe like September 11th, Litz told me, victims should not be asked to disclose their personal feelings about the event. All that is needed is "psychological first aid": victims should be taken to a safe place, given food and water, and provided with information about the status of friends and family. None of this, he added, requires the presence of a trained psychologist.

In 1917, a traumatic event on a scale similar to that of the September 11th attacks took place in Halifax, Nova Scotia. Two ships collided near the dock, one of which was carrying explosives and benzene, a flammable liquid. The crew abandoned this ship, and it drifted to the dock, where it exploded and destroyed the entire north end of the city—an area encompassing two and a half square miles. More than two thousand inhabitants were killed, and nine thousand were injured—many of them blinded and dismembered. The night after the explosion, a blizzard descended on Halifax, hindering the relief effort, and many people whose homes had been destroyed froze to death.

April Naturale is a psychiatric social worker who heads Project Liberty, a government-sponsored program that was established to coördinate the therapeutic response to September 11th. Not long ago, she went to Halifax to read archival materials on the 1917 accident. "Some of those who survived seemed psychotic, hallucinating for days," she told me. One woman continued to speak solicitously to someone named Alma—her dead child; other victims were in such a state of shock that doctors were able to perform surgery on them without using chloroform. But after a week or so these disturbing symptoms spontaneously subsided in the vast majority of cases. These accounts led Naturale to conclude that psychiatric intervention in the wake of such an event should be minimal; the mind should be given time to heal itself. In short, the "abnormal" behavior witnessed in the aftermath of the explosion was actually part of a healthy process of recovery.

Malachy Corrigan, the director of the Counseling Service Unit of the New York City Fire Department, was once a proponent of debriefing—but months before the September 11th attacks he decided that it was generally not a beneficial technique. "Sometimes when we put people in a group and debriefed them, we gave them memories that they didn't have," he told me. "We didn't push them to psychosis or anything, but, because these guys were so close and they were all at the fire, they eventually convinced themselves that they did see something or did smell something when in fact they didn't." For the workers in the pit at Ground Zero, Corrigan enlisted other firefighters to be "peer counsellors" and to provide moral support and educational information about the possible mental-health impact of sustained trauma.

"It was like one huge extended family," Corrigan recalled. "We gave them a lot of information about P.T.S.D., as well as about the burden that they would be putting on their own families. We quite boldly spoke about alcohol and drugs. And we focussed on the

anger that comes with grief, because the members were more than happy to display those symptoms. You are speaking their language when you talk about alcohol and anger. The simpler you keep the mental-health concepts, the easier it is to engage them."

Naturale sees the approach that Corrigan took, with peers providing basic comforts, as the paradigm for civilians as well as for rescue workers. "Non-mental- health professionals do not pathologize," she said. "They don't know the terminology, they don't know how to diagnose. The most helpful approach is to employ a public-health model, using people in the community who aren't diagnosing you."

Scientists are now trying to determine what causes some people to fall victim to P.T.S.D. after a traumatic event like the September 11th attacks. Rachel Yehuda, a neuroscientist at the Bronx Veterans Affairs Medical Center, has studied both combat veterans and Holocaust survivors, and has found that people with P.T.S.D. have significantly lower baseline levels of cortisol, a hormone that is released in the body during moments of stress. Cortisol, Yehuda theorizes, acts as a counterbalance to adrenaline, which is thought to play a role in the "imprinting" of horrific and intrusive memories. She speculates that the lack of cortisol allows adrenaline to act unopposed, so to speak—and this contributes to the development of P.T.S.D.

Vulnerability to P.T.S.D., Yehuda added, also depends in part on the intensity and duration of the trauma. Someone who witnessed the fall of the towers from afar is not as likely to develop the disorder as someone who worked on the fiftieth floor of Tower One and only narrowly escaped. An injury can also help precipitate P.T.S.D., and the disorder is more likely to affect a civilian bystander than someone who is trained to face dangerous situations, like a police officer. A study performed thirty-four months after the Oklahoma City bombing found that the rate of P.T.S.D. was twenty-three per cent among male civilian victims and only thirteen per cent among firefighters.

Other studies have found that people who are at greatest risk for P.T.S.D. have a history of childhood abuse, family dysfunction, or a preëxisting psychological disorder. In order to properly combat P.T.S.D., Yehuda told me, we need to have a baseline mental-health profile on everyone. "Why don't we have a doctor check our stress level?" she asked. "Just like doctors check our cholesterol."

A 1996 study of American pilots who were prisoners of war in North Vietnam underscores the importance of baseline mental health. Although the pilots endured years of torture and, in many cases, solitary confinement, they showed a very low incidence of P.T.S.D.—presumably because pilots are screened for psychological health and trained for high-stress combat.

Although there are no published studies on P.T.S.D. among rescue workers at Ground Zero, Corrigan, who has assessed many of these individuals, says it is relatively low. He estimates that, of about fifteen thousand firefighters and emergency personnel, fewer than a hundred have developed full-blown P.T.S.D. "There were a lot of therapy experts here in New York who were quite happy to tell everyone that firefighters would have P.T.S.D.," he told me. "But these folks have tremendous resiliency. People say firefighters are crazy to put themselves at risk, but they are mentally very healthy. They can sustain enormous amounts of stress and continue to function."

Some of the most promising treatment interventions for people with P.T.S.D. have been developed by Edna Foa, a professor of psychology at the University of Pennsylvania. Twenty years ago, she began a research project involving rape victims in the Philadelphia area. "Most women recover," Foa told me. "Only about fifteen per cent will develop P.T.S.D. symptoms." For these women, Foa devised a technique to "restore resilience," based on cognitive behavioral therapy. The victim is slowly taught to restructure her reactions to her memories of the rape. First, a therapist sits with the woman and asks her to close her eyes and recount the event in detail. (Unlike group debriefing, this takes place months after the event and is performed one on one.) Then the woman is told to repeat the story. Subsequent therapy sessions span some thirty to forty-five minutes each and are taped so that the rape victim can listen to them at home. "The story changes as it is relived," Foa told me. "It becomes more organized, more flowing. A narrative emerges, with a beginning, a middle, and an end."

In contrast to classical psychotherapy, which attempts to link the patient's current feelings and behavior to previous events, Foa's treatment is focussed primarily on relieving symptoms of distress. After each session, the patient is given homework assignments that are simple and direct. She is instructed to make a list of "avoidance behaviors," such as not getting into an elevator because it reminds her of the scene of her violation, and record how anxious she feels when she listens to the tape or thinks about the rape. The therapist then instructs the woman to begin to go to places that remind her of the attack. Over time, this intentional exposure to cues and memories of the trauma shifts the so-called "locus of control" to the victim, who realizes that she can control her unpleasant and intrusive thoughts.

Foa, who is an Israeli, has taught her technique to therapists with the Israel Defense Forces. These therapists recently treated thirty soldiers who had severe P.T.S.D. Some had been in continuous psychotherapy until they received Foa's treatment, which typically

requires only twenty hours of therapy. Twenty-nine of the thirty experienced a marked improvement in both their symptoms and their ability to function.

Neuroscientists and experimental psychologists are now mapping the circuits in the brain that could account for the success of Foa's treatment. For example, rats exposed to a tone and then given an electric shock learn to associate the tone with the shock, so that simply hearing the noise causes them to exhibit increased pulse, muscle contraction, and avoidance behavior—an analogue to P.T.S.D. If the tone occurs without the shock being given and is repeated on multiple occasions, the rats no longer respond with these anxiety symptoms. In a related experiment, Joseph LeDoux, a neuroscientist at New York University, made lesions in the prefrontal lobes of such fear-conditioned rats—in a part of the brain just behind the forehead. He then provided the tone without administering the shock; the animals were unable to extinguish their anxiety response, which suggests that the missing circuits play a critical role in stress management.

In recent years, Foa's technique has been used not only to treat P.T.S.D. but also to prevent it. Richard Bryant, a psychologist in Australia, has treated people who displayed sustained symptoms of acute anxiety after a motor-vehicle accident or an assault. In three randomized controlled trials, six months after the trauma, patients who had received treatment were three times less likely to develop P.T.S.D. compared with members of the control group, which received only supportive counselling.

Despite considerable evidence in the United States and abroad showing that treatments like those developed by Foa can ameliorate established P.T.S.D.—and possibly help prevent the disorder in people with acute stress reactions—her approach has not been widely adopted. Most counsellors find cognitive-behavioral techniques unappealing. Dr. Steven Hyman is a neuropsychiatrist and the provost of Harvard University; in 2001, he was the head of the National Institutes of Mental Health. "When I was N.I.M.H. director, I was upset by how few people wanted to learn cognitive-behavioral therapy," Hyman told me. "Here was a therapy proven to be effective by clinical trials. But psychologists and psychiatrists are so interested in people, and they want to cure you with their understanding and empathy and connection. The cognitive-behavioral approach is by-the-book, mechanical, pragmatic. The therapists find it boring. It's not their idea of therapy, and they don't want to do it." Debriefing holds more allure for most counsellors, for it reflects a prevailing cultural bias; namely, that a single outpouring of emotion—one good cry—can heal a scarred psyche.

Foa's method has begun to find some adherents. Malachy Corrigan, of the F.D.N.Y., now uses cognitive-behavioral techniques with several groups, including firefighters who narrowly survived the collapse of the towers. In November, 2001, Foa came to New York and trained forty therapists in her technique. Now Columbia University is offering seminars to therapists who are interested in learning Foa's approach.

At the same time, the scientific critique of debriefing has begun to have an impact. The Department of Defense, the Department of Justice, the Department of Veterans Affairs, the American Red Cross, and the Department of Health and Human Services have all abandoned it as a therapeutic method. Bruce Blythe's company, Crisis Management International, which is based in Atlanta, recently decided to discontinue its debriefing service. This week, the American College of Neuropsychopharmacology Task Force on Terrorism will release a paper recommending that debriefing be abandoned as a mainstream prevention method. Nevertheless, many for-profit companies in the so-called "grief industry" continue to offer single counselling sessions that are fundamentally linked to Mitchell's seven-step technique. And debriefing is still widely embraced; counsellors for the N.Y.P.D. and the Los Angeles Fire Department continue to use the method.

Perhaps the solution, Hyman said, is to drop the idea that "counselling" is necessary. He told me that the way we respond to individual or mass trauma should be guided by how we behave after the loss of a loved one. "What happens when someone in your family dies?" he said. "People make sure you take care of yourself, get enough sleep, don't drink too much, have food." Hyman pointed out the different rituals that various cultures have developed—shivah among Jews, for instance, and wakes among Catholics—which successfully support people through grief. "No one should have to tell anyone anything!" he said. "Particularly not in the scripted way of a debriefing." The traumatized person should share what he wants with people he knows well: close friends, relatives, familiar clergy. "It's so commonsensical," Hyman said. "But the power of our social networks—they are what help people create a sense of meaning and safety in their lives." ♦

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ESSAY; Bread and Shelter, Yes. Psychiatrists, No.

By SALLY SATEL, M.D.

Days after the tsunami struck South Asia, American mental health workers flew to Sri Lanka to offer counseling services to grief-stricken victims.

"Psychological scarring needs to be dealt with as quickly as possible," one psychologist told The Washington Post in January. "The longer we wait, the more danger."

Sri Lankan health officials saw things slightly differently. They discouraged aid agencies that offered to send counselors to their country.

"'We believe the most important thing is to strengthen local coping mechanisms rather than imposing counseling," Dr. Athula Sumathipala, chief of the psychosocial desk at the Sri Lankan government's Center for National Operations, told The New York Times the same month.

I found the contrast between the two men particularly striking because I had recently gone to Rome to attend an international conference on trauma. The conference, titled "Project One Billion," was organized by Dr. Richard Mollica, a psychiatrist at Harvard, under the auspices of the World Bank, the World Health Organization, and humanitarian nonprofit organizations. The United States also provided support.

"One billion" signified the number of people worldwide, roughly one in six, suffering the psychological consequences of war, torture and terrorism. And though these people suffered human-caused horror rather than natural disaster, the question still applies: can outsiders bearing therapy provide meaningful help in times of crisis?

One thing is clear. Even before strife ripped these societies apart, many of them had pitiful mental health systems. According to the W.H.O., most developing countries have fewer than 1 psychiatrist per 100,000 people; in rural areas, the gap is even larger. The entire country of Rwanda has only one psychiatrist. (The United States has about 14 psychiatrists per every 100,000 people; England has about 4 per 100,000.)

Experts at the conference emphasized four undertreated mental conditions: psychoses (mainly schizophrenia), major depression, drug and alcohol abuse, and epilepsy (a neurological disorder often treated by psychiatrists). They noted that depression and drug and alcohol abuse increased in the aftermath of violence and destabilization. When they spoke of post-traumatic stress disorder, on the other hand, it was more as a nod to the organizing theme of the meeting.

True, suffering was abundant -- "We cannot dry our tears," said one African representative -- but psychiatry was not the obvious answer.

It would not be the first time that psychological aid was regarded by non-Western recipients as a kind gesture but a bad fit. For the last 15 years or so, humanitarian workers have been exporting the concept of post-traumatic stress disorder and trauma counseling around the globe.

They have rushed in to impose Western "debriefing" -- a group therapy technique intended to get victims to express their feelings about a horrific event and to relive it as vividly as they can -- without regard to the needs of the victims, their natural healing systems or their very conception of what mental illness might be.

Indeed, as literature from CARE International put it during the Balkan conflict: "Almost everyone in Kosovo will consider her- or himself traumatized."

But is this true?

Several years ago, a resettlement project run by the United States government for Albanian Kosovars at Fort Dix, N.J., was staffed with mental health specialists prepared to treat high rates of post-traumatic stress disorder among the refugees. Those expectations were not met, observed Elzbieta Gozdziak, an anthropologist at Georgetown University who was part of the team. "Only 7 of the 3,000 refugees were found to need psychiatric care," Dr. Gozdziak said.

Indeed, many program evaluations reveal that actual use of specialized psychological help is typically low.

Kenneth Miller, a psychologist in the Bosnian Mental Health Program in Chicago, saw much suffering among his clients -- they had been placed in concentration camps before migrating to the United States -- yet the most successful feature of his program was not therapy, which most clients rejected anyway. It was practical help like education and job training.

Dr. Elie Karam, a psychiatrist at the Institute for Development, Research and Applied Care in Beirut, who attended Project One Billion, similarly concluded that post-traumatic stress disorder was not a major issue.

"What we found was that the violence served as a catalyst for the destabilizing effects of pre-existing problems in people's lives such as poverty, marital discord, physical illness," Dr. Karam said.

Project One Billion reflected this philosophy. Debriefing, Dr. Mollica stated, has been discredited in clinical trials.

In its place, he strongly urged that Western mental health workers collaborate with indigenous healers. The W.H.O. now instructs aid workers to "listen, convey compassion, assure basic physical needs, not force talking, and provide or mobilize company preferably from family or significant others."

Notably, mental health advisers acknowledge that local economic and social recovery is a prerequisite for improved psychology, not a consequence of it. As Dr. Mollica put it, "the best antidepressant is a job."

The very same week that Project One Billion took place, a "Dare to Act" conference was held in Baltimore. Supported by federal tax dollars, the conference promoted an inward-looking "trauma paradigm," holding that childhood and adult traumatic experiences lie at the root of most psychopathology.

A colleague of mine who works with Bosnians, Hmong and Somali refugees told me he was asked by organizers of the conference to provide a refugee woman to talk about "her trauma" at the conference.

He asked around but couldn't find one. "They don't want to think of themselves as victims," he said.

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FREE MINDS AND FREE MARKETS

The Mental Health Crisis That Wasn't

How the trauma industry exploited 9/11.

Sally Satel and Christina Hoff Sommers | August/September 2005 Print Edition

On September 14, 2001, three days after the terrorist attacks on the World Trade Center and the Pentagon, a group of psychologists sent an open letter to the American Psychological Association. The 19 signatories, all established experts in trauma research and treatment, were concerned that thousands of people in New York City and elsewhere would receive dubious, even damaging, counseling. "In times like these," the letter said, "it is imperative that we refrain from the urge to intervene in ways that--however well-intentioned--have the potential to make matters worse....Unfortunately, this has not prevented certain therapists from descending on disaster scenes with well-intentioned but misguided efforts. Psychologists can be of most help by supporting the community structures that people naturally call upon in times of grief and suffering. Let us do whatever we can, while being careful not to get in the way."

The letter voiced a second powerful warning: not to mistake normal reactions--intense sadness or sleeplessness, jumpiness, and so on--for mental abnormality. The letter was posted online and picked up by a *New York Times* science reporter who fast-tracked the controversy into Sunday's paper, five days after the attacks. As Gerald Rosen, a Seattle psychologist and one of the letter's authors told the reporter, "The public should be very concerned about medicalizing what are human reactions."

By then, though, the trauma industry had shifted into high gear. Roughly 9,000 counselors raced to lower Manhattan, advocating, in the words of one observer, "intervention for any person even remotely connected to the tragedy."

Spencer Eth, a psychiatrist at St. Vincent's Catholic Medical Centers in New York City, foretold "huge increases in the prevalence of traumatic grief, depression, post-traumatic stress disorder [PTSD], and substance abuse in the New York City metropolitan area at the least...[the] psychiatric toll will be enormous." Richard Mollica, a Harvard psychiatrist, forecast that "starting around the Thanksgiving holiday and through the New Year, a major mental health crisis will emerge in the city and surrounding area." The president of the New York State Psychiatric Association predicted that psychiatric problems would continue to emerge over several years, including among those who were watching television coverage of the attack.

Granted, these urgent statements were made soon after the attacks, while our collective nervous system was still reverberating from the shock. Yet weeks and months later, when cooler heads might have prevailed, the warnings remained frantic and grim. In June 2002, for example, the Office of Mental Health projected that two million New Yorkers, or one in four, would need counseling. And one year after the attack, the president of the Washington, D.C., Psychiatric Society was still worried about mental health manpower: "There are not enough psychiatrists, psychologists, social workers, or other crisis counselors to treat the fallout from a massive, unimaginable horror."

The dire predictions of psychological injury prompted a *Washington Post* reporter to correct the misimpression: "Even though it is commonly believed that post-traumatic stress disorder is universal among trauma victims--a fallacy that some mental health counselors are perpetuating in the aftermath of this tragedy--epidemiological studies show otherwise." In response to the apprehension about whether people could cope, a skeptical reporter with *USA Today* was finally forced to ask, "Does everyone who goes through trauma need a therapist?"

The answer, of course, is no.

The Trauma Industry

Therapism is a worldview that valorizes openness and emotional self-absorption; it assumes that vulnerability, rather than strength, characterizes the American psyche, and that a diffident, anguished, and emotionally apprehensive public requires a vast array of therapists, self-esteem educators, grief counselors, workshoppers, healers, and traumatologists to lead it through the trials of everyday life.

In fact, there is no evidence that large segments of the population are in psychological free fall. On the contrary, researchers who follow the protocols of social science find most Americans--young and old--faring quite well. If they're crashing and burning, they don't seem to know it. This has proven true even in the wake of terrible disasters.

Trauma counseling flowered with the Oklahoma City bombing of 1995--where counselors reportedly fought over patients "because there were simply not enough to go around"--and the TWA Flight 800 air disaster of 1996. After the Columbine High School massacre in 1999, counselors logged 1,500 hours talking to students in the first week alone, according to *Time*. This "psychological debriefing" involves a counselor--who has never before met any of his victim-clients--conducting group-therapy with those individuals for a few hours, encouraging them to emote. Typical questions include "What were the first thoughts that raced through your mind at the time of the crisis?" and "What was the worst moment for you?"

This bears little resemblance to its precursor: military operational debriefing. After a significant battle in World War II, soldiers were "debriefed" by their superiors. The aim was to establish what happened for historical purposes, identify plans that had gone awry or well, share experiences, boost morale, and facilitate troops' rapid return to duty. The mitigation of distress was a welcome byproduct, but operational debriefing was not designed as a psychological aid.

In the 1960s and 1970s these frontline principles were translated into peer-to-peer support activities for rescue workers. Firefighters, paramedics, and other emergency workers who routinely witnessed horrible scenes of carnage and risked their lives in the line of duty would gather to review the logistics of an operation and talk about their experiences. Over time, the debriefing process was extended to civilians. As a form of psychological first aid, it joined--and sometimes displaced--traditional crisis work, which had grown out of crisis theory elaborated in the 1960s. The basic tenets of crisis theory are that people who have endured a life-threatening event are not sick and that crisis intervention is not necessarily a mental health service. The main job of a crisis worker or counselor is to help the client find concrete, realistic solutions to the problems created by the event.

This perspective differs fundamentally from the more recent model created by Jeffrey T. Mitchell, a former paramedic and firefighter. In the late 1980s Mitchell began to market his crisis philosophy that virtually all victims are at risk for trauma-induced mental illness. If crisis workers shore up people who are basically sound though temporarily in disarray, psychological debriefers give a mixed message. On one hand, they tell victims that stress reactions are normal, and yet warn that without their intervention such reactions can easily blossom into PTSD.

All manner of setbacks qualify a worker for psychological help. According to *Psychotherapy Finances*, a newsletter for entrepreneurial therapists, "workplace trauma isn't just about bank robberies or shooting sprees...for every high-profile incident there are thousands you never hear about." When a tasteless cartoon about firemen appeared in the *New York Post* two years after the attacks, the Fire Department of New York City sent counselors to a company that had lost men on 9/11. "We wanted to make sure the guys were all right," a FDNY official told the New York *Daily News*.

Business and corporate managers have jumped on the psychological debriefing bandwagon, persuaded by its purveyors that without their help productivity will suffer and mental health costs will soar. Organizations that do not offer debriefing for workers exposed to on-the-job trauma "may put themselves in medical-legal jeopardy," warns Landy Sparr, a psychiatrist at Oregon Health and Sciences University. Some psychologists even tell employers that they have 48 hours to act after a disaster, otherwise employees may "jump ship" or "come down against the company."

Trauma Tourism?

The International Critical Incident Stress Foundation (ICISF), based near Baltimore, is the largest psychological debriefing training outfit in the world. With a virtual monopoly on debriefing training, ICISF appears to be prospering both at home and abroad. Its clients include the FBI, the Coast Guard, the American Red Cross, and U.S. Air Force bases worldwide. It has training programs in Canada, Europe, the Caribbean, Central and South America, and Australia.

Anyone with a high school diploma is eligible for the foundation's course. In some circumstances, an ICISF certificate grants the bearer access to disaster sites that an advanced clinical degree does not. For example, in 1995 a group of psychiatrists from Yale that included respected experts in traumatic stress offered to help with victims of the Oklahoma City bombing. Emergency officials turned them away because they lacked certification from the International Critical Incident Stress Foundation. The certificate, then, doubles as a coveted passport to disaster sites--even though it is awarded to anyone who has paid the $190 course fee and shown up for the lectures. Is it any coincidence that critics of the crisis management business have taken, tongue-in-cheek, to calling volunteer crisis counselors "trauma tourists"? There is no doubt that the volunteers are well meaning, but neither is it any secret that some of them have a voyeuristic urge to be part of a historic moment or a media event.

"Disaster vultures" was the name given to overly enthusiastic mental health professionals who rushed into the scene at the Oklahoma City bombing in 1995. "Their credibility in the future would be their claim to have worked in Oklahoma City," a dismayed local psychologist observed.

Psychological debriefing is an enterprise that has operated outside of conventional clinical boundaries and oversight. Richard Gist, a psychologist with the Kansas City, Missouri, fire department and an outspoken critic of the trauma industry, describes it as a prolific and parochial subculture of providers whose understanding of these highly complex issues is often limited to proprietary instruction in the form of traveling seminars, trade magazines, and paperback books, rather than the refereed venues of empirically guided professional practice.

In the summer of 2002, one of us (Satel) spent two days in a frigid hotel ballroom outside Baltimore with about 200 men and women--nurses, social workers, rescue volunteers--seeking ICISF certification in the basics of crisis counseling. Much of what the instructor said was obvious: that routines should be preserved after a crisis,
that too much alcohol is bad, that depriving yourself of sleep is unhealthy, and so on. The "experts" had appropriated common sense as if it were their own special province.

Then came a session on psychological debriefing, also known as critical-incident stress debriefing--the centerpiece of trauma counseling. Our instructor acknowledged that debriefing had come under attack, but promptly dismissed the critics, maintaining that psychological debriefing was proven to thwart the development of PTSD.

The instructor peppered us with a series of half-truths and outright misstatements. We were told, for example, that PTSD "rarely goes away by itself," that there are no factors that predispose a person to develop PTSD, and that people who "hold it in do worse"--all untrue statements. The course manual stated that debriefing compensates for "the failure of the [victim's] usual coping strategies." Moreover, unless psychological debriefing took place soon after the crisis, a "trauma membrane" would form around the victim and "thicken" so that he would no longer be receptive to help. (Ironically, the psychiatrist Jacob Lindy, who treated survivors of the devastating Beverly Hills Supper Club fire outside Cincinnati in 1977, coined the term *trauma membrane* to describe not a debriefing-resistant cocoon but a small network of trusted friends who buffer the victim from additional stress. A properly functioning trauma membrane, in Lindy's sense, might well act to keep debriefers away.)

We also learned how to conduct a psychological debriefing by breaking up into groups of eight. Each group was provided its own tragic scenario. In ours, we were supposed to be telemarketers busy on the phones one morning when an employee's drunk and jealous ex-husband burst into the work area with a gun and shot one of us in the shoulder. After the injured worker was taken away in an ambulance, the rest of us gathered to be debriefed by our eighth colleague, who was assigned the role of an outside debriefer. Following the directions in our course manual, the role-playing debriefer encouraged us to talk about how scared we were, rehashing in the most graphic language how the blood had spurted from our colleague's wound, how we had panicked and had thought we would all be killed. This was our "opportunity for catharsis, an opportunity to verbalize trauma," said the manual.

First, Do No Harm

Such opportunities are precisely what the 19 psychologists' open letter warned about when it spoke of therapists "descending on disaster scenes with well-intentioned but misguided efforts." And with good reason. Research shows these efforts at debriefing to be ineffective in preventing the development of PTSD or related symptoms, and, at times, to actually be harmful.

Most random-assignment studies of individuals who have suffered accidents, assaults, or burns show the same degree of improvement, whether patients were debriefed in a one-on-one session by a therapist or instead received general support or no intervention at all. Two such studies, however, found that debriefing actually impeded recovery. In one, debriefed burn victims were three times as likely as the control group to develop PTSD after one year. In the other study, a three-year follow-up of car accident victims, anxiety, level of functioning, physical pain, and degree of preoccupation with the accident improved more slowly in the debriefed patients than in the control group.

Britain's National Health Service, the North Atlantic Treaty Organization, and the World Health Organization all cautioned against the use of debriefing as possibly harmful. In the fall of 2002, the National Institute of Mental Health (NIMH), in collaboration with the Red Cross and the U.S. Departments of Defense, Justice, and Veterans Affairs, released a report on psychological interventions in the wake of disaster. "A sensible working principle in the immediate [aftermath] is to expect normal recovery," said the report.

How can debriefings make things worse? First, venting emotions and reviewing experiences repeatedly in the immediate aftermath of a crisis can interfere with victims' natural adaptive instinct to distance themselves emotionally. They may start ruminating about

the event--fixating on why it happened, how life is now ruined, whether revenge is possible--thus intensifying intrusive memories and overall distress.

Second, debriefing might lead people to believe that they have now received "treatment" for distress and no longer need to, or should, disclose their anxieties to family and friends. This deprives victims of the comfort and reassurance that are usually best supplied through established, intimate relationships. Paradoxically, knowing that professional debriefers are involved may even cause family and friends to hang back.

Third, by warning participants of the kinds of reactions that could develop over the coming weeks, debriefers might inadvertently prime victims to interpret otherwise normal reactions as pathological or as the beginning stages of PTSD. As the psychiatrist Simon Wessely has remarked, "The toxic effect of counseling is that some people begin to see themselves as having a mental health problem when they do not."

Where Are All the Patients?

In October 2001 Sharon Kahn, a senior psychologist at Coney Island Hospital, manned the phones at a televised call-in show sponsored by PBS and called *Reach Out to Heal*. Experts described the symptoms of traumatic stress, and viewers were urged to phone in with questions and to get referrals for help.

Kahn took calls all evening. She referred a grand total of two people for therapy. The vast bulk of the calls were queries about the resumption of regularly scheduled programming.

Across the country, mental health professionals braced for epic caseloads after September 11. Yet in the end, the demand for their services was modest. According to the New York Academy of Medicine, which conducted numerous surveys after the terrorist attacks, roughly 19 percent of New Yorkers said they saw a mental health professional within the eight weeks after the event--but this was little more than the 17 percent who did so eight weeks before the attack. "Existing therapeutic relationships and informal sources of support were the primary mental health resources for most people within the first few months," according to Dr. Sandro Galea of the Academy.

According to an Academy study published in 2004, there was no evidence that the predicted waves of delayed PTSD were surfacing, at least within the first five months after the attacks. Mental health service use declined steadily within the first five months after attacks to virtually pre-9/11 levels. "The increase was not clinically significant," Dr. Joseph A. Boscarino, the study's lead author, told *The New York Times*, "We expected higher use rates."

For about a year after the attacks, star-studded public service announcements were ubiquitous in subways, buses, and newspapers around New York City. "Whatever you are struggling with, you are not alone," the actor Alan Alda intoned on radio stations serving New York City. "Now is the time to feel free to feel better." The ads were sponsored by Project Liberty, the name given to the crisis counseling program in New York City funded by the Federal Emergency Management Agency (FEMA) and run by the New York State Office of Mental Health.

Project Liberty's four thousand counselors offered reassurance and advice. They met with groups of people and with individual clients. They made house calls, arranged to meet clients on park benches or at their workplaces. When the New York State Office of Mental Health applied for its first FEMA counseling grant right after September 11, it estimated that 1.5 million New Yorkers would need counseling. A grant of $23 million came through promptly in October. As of June 2002, about 120,000 had sought assistance, not even one-tenth the projected number. Yet around that time, FEMA announced another grant, of $132 million--nearly six times as large--in response to a second request for counseling funding. This time, the Office of Mental Health projected that two million New Yorkers, or one in four, would need counseling ("to allow necessary healing to continue").

In the late spring of 2003, about a year after the second FEMA grant was awarded, $90 million remained unspent, according to the New York *Daily News*. Recruiting clients was a priority. "In New York City," said Rachel Yehuda of Mount Sinai School of Medicine, "the strong feeling was that if [the clients] don't come to you, you've got to go to them. The idea was to institute portable Project Liberty units of people to walk the streets looking for people to help." In the winter of 2002 Lynne Rosen, a psychotherapist in Brooklyn, got a part-time job offer in just that spirit. She was contacted by a representative of a Queens-based mental health center to "reach out" to the traumatized residents of Brooklyn and Staten Island. The center would pay her with funds obtained from Project Liberty. Rosen's assignment was to sit in the waiting room of a general practitioner's office and approach patients as they came in for their medical appointments. She was to ask them where they had been on September 11 and whether they were having any psychological problems because of it. If so, she was to refer them to a center therapist.

The center wanted Rosen to talk to the patients about PTSD, she said, "even if they responded to the question about symptoms with a definite no." So she asked the center's representative how he justified such aggressive conduct. "'We all continue to be deeply affected by September 11,' he told me indignantly," Rosen said, "and he lectured me that future psychiatric symptoms could still develop." Rosen turned down the offer because she could not picture herself "accosting these unsuspecting people and burdening them with unnecessary anxiety about an event that happened over six months ago and that they said did not have a lasting effect on their well-being."

Private charities made mental health services a priority after September 11. They "have taken perhaps the most aggressive stance ever in pushing mental health therapy for families and others affected by the attacks," noted *The Washington Post*. In the summer of 2002 various New York City-based charities, along with the Red Cross, announced combined grants of almost $250 million over five years (including the FEMA support) to "address the enduring problem of psychic damage--grief, stress, trauma--in the aftermath of September 11." A year later these same charities announced a collaborative effort "to encourage people affected by the 9/11 attacks to take advantage of financial assistance for confidential mental health and substance abuse assistance."

Pessimism, Pathologizing, and Profiteering

This money was pouring forth even as evidence consistently showed that most people were improving with time. Polls taken by the Pew Research Center, the Marist Institute for Public Opinion, ABC/*Washington Post*, and RAND within six months of the attacks all showed declines in problems such as sleeplessness, trouble concentrating, and intense worry about future attacks. Volumes of data on traumatic response confirm that rates of stress and PTSD decline with time.

Why did the money keep flowing? Partly because mental health planners, lacking data on nonpathological responses to terrorist attacks, relied on models that were inappropriate--chiefly from the Oklahoma City bombing and other mass disasters where death or injury was widespread. The victims of such events bore little resemblance to the vast majority of New Yorkers, who, while deeply shaken, even devastated, were never in mortal peril.

In addition, officials believed more people would use trauma services in the future. "Based on our experience, we know that thousands more need these services but have not come forward," the administrator of the American Red Cross's September 11 Recovery Program announced. Once they recognized that they needed help or got over their fear of being criticized for seeking it, the assumption was, many more New Yorkers would be getting therapy. Fully three years after the attacks, the Mental Health Association of New York City was still advertising counseling services for reactions to 9/11.

Continued funding was also justified by the expectation that symptoms had yet to manifest themselves. Joshua Gotbaum, the chief executive of the September 11th Fund, informed the public that "many people affected by September 11 will need some form of counseling and that many of them will not realize it for months or even for years." Dr. Paul Ofman, chairman of emergency services at the Red Cross in Greater New York, also expected to see delayed reactions: "While for some people, the impact on their mental health is evident right away," he told *The New York Times*, "for a noteworthy minority of individuals, the impact won't become evident until months or even years after the disaster."

Finally, money flowed because service providers were eager to take it. Daryl Regier of the American Psychiatric Association issued a canny prediction when he told the Times, "There are going to be people coming out of the woodwork to capitalize on this large amount of money that's available, some of whom will be completely legitimate." And, Regier added, some of whom will not be. As Reuters reported, "A whole new era of mental health services could be opening up for longer-term care [for stress relating to the terrorist attacks] in what could be a boon for individual counselors and the companies who act as industry middlemen."

Ending an Ethos of Therapism

In New York City on September 11 there was a strong, spontaneous show of collective resolve and organization. Near Ground Zero, members of one tenant association helped direct the streams of people running from the World Trade Center; they formed an "urgent needs" team to check on homebound residents; they acted as volunteer cashiers in stores when paid employees could not get to the area. The calm and orderly behavior of workers evacuating the World Trade Center towers themselves surely kept the death and injury tolls from rising. In the largest waterborne evacuation in our history, half a million people left lower Manhattan. Barges, sailboats, and ferries, with no instructions, put into the port as the towers burned. "If you're out in the water in a pleasure craft and you see those buildings on fire," the Rutgers sociologist Lee Clarke said to *The New York Times*, "in a strictly rational sense, you should head to New Jersey. Instead people went into potential danger and rescued strangers."

According to the sociologist Henry Quarantelli, a pioneer in the field of disaster research, such constructive responses are typical. "Mythical beliefs to the contrary," he writes, "disaster victims do not panic, they are not passive, they do not become caught up in [selfish and] antisocial behavior, and they are not behaviorally traumatized." Monica Schoch-Spana, a medical anthropologist with the Johns Hopkins Center for Civilian Biodefense Strategies, laments the predominance of the "pathological model." So often, she says, officials and mental health planners neglect the positive human elements that crisis elicits, such as "reasoned caution, resourcefulness, adaptability, resiliency, hopefulness, and humanitarianism."

In our trauma-conscious society, many mental health professionals seem eager to take charge of managing the collective anxiety surrounding terrorism and its aftermath. But perhaps one of the lessons from September 11 is that the clinician's role in a shocked and heartbroken world is actually quite limited.

Consider what we know about human response to crisis. Under threat, citizens are ravenous for information and require practical resources. They need a social scaffolding in the form of civic order and some minimal infrastructure to support the bedrock institutions and relationships--families, communities, and houses of worship--that have always served them in times of uncertainty and immense sorrow.

One of the lessons of 9/11 is that therapists must find a balance between offering their services and promoting them too eagerly, between letting people know help is available and suggesting that they need help when they do not. On September 11 the helpers toiled in good faith, powered by genuine concern. But they also endorsed one of the mistaken tenets of therapism: that people are fragile. In their zeal to help, they underestimated our natural fortitude.