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How much does crisis counselling help—or hurt?

BY JEROME GROOPMAN

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."©