Commentary on "A National Study of the Psychological Consequences of the September 11, 2001 Terrorist Attacks: Reactions, Impairment, and Help-Seeking"

When Being Upset Is Not A Mental Health Problem

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I live in Central London under the Heathrow flightpath. As I write this editorial, my house has just been shaken by the final flight of the last three Concordes. Just over two years ago, on Sept 11th, we experienced the opposite, a strange week of silence, when all overflights were banned for a week. And when they resumed, for a while I looked out of my window as each plane came past, and experienced a frisson of anxiety. And like virtually everyone I know, it took some time to shake off the hypnotic images imprinted in my memory from those hours glued to our television screens throughout the horrors of that first day.

But I never considered that I had a problem, let alone sought help for it. And after a few weeks these emotions disappeared. Yes, my world view had changed—and my appraisal of the society we live in and the threats we face. The world seemed, and probably was, a riskier place (Halpern-Felsher and Millstein 2002). But emotionally and physically I felt the same as I had been before, for better or worse.

And when I visited America only a few weeks later, to take part, ironically, in a pre-arranged conference on psychological responses to trauma (NIMH 2002), I observed something else. Sept 11th had also brought about positive changes in the society that I had visited so many times. Was it my imagination, or were people genuinely more talkative, more likely to engage with me in bars, waiting rooms, and queues that are the staple of travel these days? No, on everyone's lips was the observation that adversity had brought us together, and indeed that upsurge in communitarean feelings for once even involved myself as a Britisher, finally forgiven for George III.

Should we be surprised by this? It was the great Durkheim who suggested that during periods of external threat group cohesion increases, and suicide rates decrease. Indeed, tentative evidence of a lowering of the suicide rate in the United Kingdom after Sept 11th has been presented (Salib 2003), and it would be interesting to know if the same will be observed in the United States. We are robust nations, and our citizens repeatedly surprise us by their resilience in the face of adversity—in the past (Jones, Woolven, Durodic, and Wessely, in press), and during the terrible

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events of September 11th, when panic was noticable by its absence (Glass and Schoch-Spana 2002).

Sept 11th did bring about changes in most of us. These were a complex mixture of both negative and positive. But were these abnormal? Did I need treatment for my compulsive checking of the sky over my house, or the dreams I experienced? Was any of this anything to do with the mental health professional?

It is a general principle that professionals should refrain from treating ailments that are going to get better fairly quickly anyway, since to do so wastes resources, and exposes patients to the risks of side effects of unnecessary treatment. What do we know about the emotional responses that were indeed so common after September 11th?

In their original paper, the Rand team reported that 44% of Americans had "substantial stress" in the wake of Sept 11th (Schuster et al. 2001). One or two critics did wonder if scoring "having trouble falling or staying sleep" or "having difficulty concentrating" at the "quite a bit" level as being sufficient to qualify for "substantial stress" was really compatible with the word "substantial," but never mind. The current paper shows that this figure had halved at Wave 2, taken during November, only a few weeks later.

We can compare this with the recent paper from Sandro Galea and colleagues, who conducted an equally elegant follow-up study carried out solely in New York City at one, four, and six months after the atrocities (Galea et al. 2003). Probable PTSD declined from 7.5% to 0.6% at six months, the latter figure comfortably within expected population norms. Thus we can expect that the Rand study, if it had been repeated six months after the outrages would show further decline, and I suspect would likewise return to the baseline level of psychological distress in the community. That is high enough, but that is another non-September 11th story.

Just how serious or abnormal where these manifestations anyway? We all know that there are no clear cut-offs between the normal and abnormal in psychiatry. In general, we strive to treat the abnormal (clinical depression, for example), and not the normal (sadness after the death of a loved one). After exposure to traumatic events, we often expend considerable efforts to remind people that it is normal to feel upset or shaken or to have difficulty sleeping, and that this is not psychiatric disorder or the inevitable precursor to it. Indeed, the inherent ambiguity of post-disaster interventions—which simultaneously proclaim that it is normal to feel upset when bad things happen and then to suggest a variety of therapeutic interventions—points to the importance of non-therapeutic factors underlying many institutional and professional responses to trauma. So, deciding on the boundaries between the normal and abnormal will always be a matter of discretion. And as sociologist Frank Furedi has recently argued, there is a danger that we are now getting these boundaries wrong (Furedi 2003), and actively professionalizing or pathologizing normal feelings with consequences that can be unforseen and undesirable.

One increasingly recognized boundary is that between symptoms and disorder. In our work on members of the United Kingdom Armed Forces after the 1991 Gulf War, we found elevated rates of every symptom that we inquired after, including those indicative of possible posttraumatic stress disorder (Unwin et al. 1999). And yet when we interviewed these service personnel using standardized psychiatric instruments the rate of PTSD was elevated, but only from 1% in the well veterans to 3% in the sick (Ismail et al. 2002). Many veterans had symptoms; fewer had discrete disorders mandating treatment. Symptoms alone are a poor guide to disorder, and what we should be concerned about is disorder—people who are unable to earn a living or look after their families, not those who feel transiently alarmed or anxious in a world growing increasingly alarming.

Symptoms might indicate disorder, but then again they might not. It is a dilemna exemplified in the paper from the Rand team in this issue. On the one hand, the authors repeat

the warning about the importance of recognizing significant distress that does not reach levels that qualify for a diagnosis. Yet on the other, they also point out that the responses in this study (i.e., individuals who were still bothered by their emotional reactions to Sept 11th) should not be viewed "in any way to be indicative or predictive of a clinical disorder." Which is it to be? If symptoms are neither indicative nor predictive of psychiatric disorder, then why as clinical psychiatrists and/or psychologists should we pay attention to them or ask others to pay attention?

Instead, is it not our duty to make it clear that these do not constitute a psychiatric disorder? That is exactly the view espoused by many professionals who become involved in the immediate psychological management of those exposed to trauma. Most of the interventions with which I am familiar involve some form of education to the effect that we all feel like this, that this does not mean you are going mad, and that it is all perfectly understandable.

When we strip away the current paper, beautifully and indeed rapidly executed by the Rand team (and am I alone in envying the alacrity with which they managed to cut through the research-stifling bureaucracies of our overblown Institutional Review Board systems to actually get into the field only days after Sept 11th?), what do we have? We have a large sample of people like myself, people who felt both emotional distress and greater social involvement in the days after Sept 11th, people who did indeed experience emotional change, and sometimes visible distress, but whose emotions were understandable, not abnormal, and did not indicate a lifetime of psychiatric illness. Indeed, such emotions began to disappear in a matter of weeks. And as these papers tell us, they did so largely without the benefit of help from a mental health professional.

And yet the leitmotif of so much of the Sept 11th literature emerging in the mental health field is the call for more and better interventions and resources that need to be deployed more quickly. I have yet to see a complete audit of exactly what resources were committed to post-Sept 11th—in New York City in particular. One reads of hotels occupied by teams of counsellors, but this may represent modern mythology. Approximately $21 million was allocated in federal funds to provide free counselling for New Yorkers ("Project Liberty") (Kadet 2002), with an additional $131 million requested for therapist salaries. Predictions were made that one in four New Yorkers would require mental health assistance, and emergency workers appear to have received obligatory counselling. Another survey suggested that 28% of working Americans had been offered work place counselling after Sept 11th.

Some have questioned the assumption that even this was not enough, and that more could and should have been done. Few have questioned the wisdom of what actually was done. Leaving aside those directly affected, by which I mean direct survivors and the bereaved, were increased resources needed for the rest of population? And what should those resources have consisted of?

The answer is that we don't know. It would be fair to say that a consensus was not reached at the conference on early psychological interventions after trauma (NIMH 2002). The weight of opinion was against giving blanket interventions to normal people, most of whom were either not distressed or, if so, were going to get better anyway—although the corridor conversations indicated that this was precisely what was happening on the ground even as we debated. Some (this author included) worried about the possibilty of causing more harm than good, and remain troubled by the proliferation of interventions, high in enthusiasm and charisma, but low in evidence of effectiveness. Our past should leave us in no doubt that as mental health professionals we do have the power to create disorder as well as treat it (Dineen 1996; McHugh 1999). Likewise, we have a rather better record in treatment than prevention. So for us, the mental health professional's role in the immediate aftermath of disaster was to be supportive and advisory to those making the decisions and managing the consequences,

but otherwise to be there only when called upon, which would be infrequently.

Others preferred to target scarce resources on the immediate minority who really needed help, rather than the majority who didn't. A recent scholarly review echoes this conclusion (McNally, Bryant, and Ehlers 2003), highlighting a rapidly developing literature which is starting to suggest that the strategy with the most promise is to target only the minority with acute stress reactions—acute stress disorder (ASD) in civilian practice, combat stress reaction (CSR) in military practice. And successful intervention involves not a single-session stress debriefing, but a more focussed and lengthy cognitive behavioral intervention, which not everyone is qualified to deliver (McNally et al. 2003).

This is not, and is not meant to be, an intervention to be implemented on a population level. So what do we do for the rest? Here's the hard part. Speaking now as a mental health professional, why do we need to do anything at all? Yes, there is a desire to "do something." None of us like to see people in distress. The desire to help our fellow human beings is one of the more attractive aspects of human nature. Of course, in times of crisis we must be good neighbors, loving parents, loyal colleagues, and sensitive employers. But beyond this good citizenship, is there a role for us as psychiatrists, psychologists, or other mental health professionals? In our increasingly disconnected world, what is needed is encouragement for people to develop the social networks that are known to decrease distress and increase relience. Do our blanket interventions assist or detract from this? Is this one reason why some controlled studies have shown an apparently paradoxical effect after psychological debriefing—an increase, not a decrease, in psychological distress (Gist 2002; Emmerick, Kamphuls, Hulsbosch, and Emmelkamp 2002)?

We now have evidence-based treatments to help those minority of citizens who do go on to develop serious psychiatric disorders, including, but not restricted to, PTSD, after trauma. And yet we also know that many, perhaps most, of these people still do not receive the best available treatments. This reviewer feels that we should not expend resources for those who probably don't need our help, but instead concentrate on those who would benefit from our modern interventions, but are most likely not receiving them.

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