WORKING PAPERS

The Psychotherapy of Trauma and The Trauma of Psychotherapy: Talking to Therapists About 9-11

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INTRODUCTION

In the hours following the 2001 terrorist attack on the World Trade Center, New York City hospitals prepared to receive the wounded. At St. Vincent's Hospital in Greenwich Village, gurneys dressed in clean white linens were neatly arrayed along Seventh Avenue, awaiting a deluge of injured survivors. But the hospital beds remained empty; the physically wounded did not materialize. In lieu of bodily injuries, many of those who survived the attacks suffered wounds that were psychological. As the loss of life, the property damage, and the terrorist threat were measured, and as the shock and fear set in, attention turned to psychological injuries, and to public mental health.

This chapter examines the ways in which New York City mental health professionals, who treated the psychologically injured in the days, weeks and months after the attack on the twin towers, have been personally and professionally affected by their work. Treating the wounded has required psychotherapists to help individuals suffering from a particular traumatic event that they too, simultaneously, experienced. It has required them to confront the collective wounds sustained by a densely populated urban community numbering in the millions. Further, it has required them to reevaluate their relationship to public mental health.

Studies show that disasters cause extensive psychological harm; that they are injurious even to persons who do not suffer direct personal losses, and who are far removed from areas of actual physical damage (Vlahov 2002). Disasters that damage property and the economy, that are humanly caused and intentional, and that involve acts of mass violence, tend to produce the most severe and pervasive distress (Norris 2002). Accordingly, following the terrorist attack of September 11, 2001, experts in public health anticipated widespread emotional disturbance throughout the entire New York metropolitan area. Given the unprecedented nature of this attack, they had little basis for accurate estimates of the number of persons who would be psychologically harmed, and produced a range of predictions. Some public health officials

considered every resident of New York State to be at risk. They foresaw mental health problems for

> "the over 8 million residents of New York City; 4.7 million residents of the surrounding counties, where many of the direct victims lived; and residents of the rest of the state, who saw these traumatic events on television" (Jack & Glied 2002:332).

Others sought to more precisely estimate the attack's psychological consequences by applying rates of mental disorder found in Oklahoma City after the1995 terrorist bombing. These public health officials projected that 34% of those who were "most exposed"—including persons who were injured in the attack, families of the injured and the deceased, rescue workers and their families, and World Trade Center employees and their families--or approximately 528,000 people, would develop posttraumatic stress disorder (Herman et. al. 2002a). They also projected that more than three million New York metropolitan area residents would experience substantial psychological distress (Herman et. al. 2002b).

Early studies of the mental health consequences of September 11 supported predictions of elevated rates of psychological disturbance. In a survey conducted a week after the attack, 61% of those who lived within 100 miles of the World Trade Center reported that they were experiencing traumatic stress (Schuster et. al. 2001). Studies in the first few months after the attack found a higher incidence of symptoms of post-traumatic stress disorder after 9-11 (Galea et. al. 2002), as well as increased consumption of alcohol, cigarettes and marijuana (Vlahov et. al. 2002) among New York City residents. Increases in psychological distress were not limited to adults; tens of thousands of New York City children developed a range of psychiatric symptoms, including nightmares, anxiety, and agoraphobia, in reaction to the attacks (Goodnough 2002).

To address such widespread mental distress, the New York State Office of Mental Health designed Project Liberty, a disaster mental health program strikingly different from the usual mental health initiatives. Promised more than $150 million in federal government funding, Project Liberty was soon up and running. Within a month and a half of the attack, it had hired new

counseling staff; trained thousands of mental health professionals in disaster mental health and community outreach; designated hundreds of existing agencies as program sites; created television and print publicity campaigns to educate the public about traumatic stress; and extended free counseling to anyone affected by the attack (Felton 2002). Not only were free mental health services made available, but they were aggressively marketed. Project Liberty's services were advertised on buses and subways, on the radio and on television, and on postcards and paper cups (Wunsch-Hitzig et. al. 2002). Celebrities were hired as spokespersons to reduce the stigma of seeking mental health treatment in response to the attack (Jack & Glied 2002).

While New York State's mental health programs were in place within weeks of September 11, New York City psychotherapists responded within hours. Immediately following the attack, hundreds of therapists contacted disaster relief organizations and their professional groups to learn what they might do to help. Beginning that day, and for the next several months, therapists volunteered their services. They worked in the Armory, helping persons search for the missing; on telephone hotlines, helping callers who could not locate their relatives; at the Pier, consoling the families of the deceased; at Family Assistance Centers, aiding the newly displaced and unemployed; and at Ground Zero, supporting rescue and recovery workers. Mental health agencies sent staff, and university departments sent faculty, to comfort employees at firms suffering heavy civilian casualties. Therapists in private practice provided free psychological treatment to evacuees, rescue workers, and families of victims; those who specialized in trauma and disaster went to work training others who lacked such skills. Therapists donated their help in firehouses, community centers, corporate boardrooms, and schools, and on city streets. While there is no precise count of the number of psychotherapists who delivered mental health services after 9-11, in the weeks and months following the attack, therapists seemed to be everywhere. If there are indeed "eight million 9-11 stories" in New York City (Rich 2002), then there are untold numbers of therapists who have listened to thousands of them.

METHODOLOGY

Research objectives

This research has three primary objectives. First, it investigates the professional consequences of the events of September 11, 2001, for psychotherapists in the New York metropolitan area. How did therapists respond to this unexpected and deadly act of mass violence? Were they prepared to intervene in an event of this nature and scope--one that injured communities as well as individuals? What kinds of mental health services did they provide, and in what settings did they provide them, after the attack? How did they conceptualize their relationship to public mental health? Did they alter their practices, or develop new ways of practicing, to meet the demands of this crisis? Have psychotherapists prepared themselves to respond to future terrorist acts?

Second, this research investigates the personal consequences of September 11 for New York's therapeutic community. In keeping with the particular characteristics of clinical encounters, many therapists have spent the past year listening closely and repeatedly, on an ongoing basis, to patients' most terrifying and excruciating experiences. How has their intense and intimate exposure to patients severely injured by the attack affected them? Do patients' accounts of 9-11 differ from other clinical accounts of violence, disaster, and horror? What are the emotional consequences for therapists who simultaneously experience the same catastrophic events as their patients? What are the psychological costs of providing psychological services?

Third, this research investigates the mental health consequences of September 11 through therapists' reports of their patients' psychological responses to the attack. Previous studies have described these consequences by calculating rates of psychiatric symptomatology; yet individuals' emotional reactions to the attack, and to its enduring effects on their lives, cannot be fully expressed in these terms. Because therapists hear patients' private thoughts and fears, and because they observe manifestations of distress that patients refer to implicitly, enact indirectly, or express somatically, they are likely to have information on New Yorkers' responses

to the attacks that is not available from any other source. What do therapists' reports of clinical encounters since 9-11 tell us about the range of individuals' emotional responses, and about the psychological effects of terrorist attacks on a large urban population?

Interviews

To carry out this research, I employed qualitative methods, conducting in-depth, intensive interviews with individual psychotherapists. My interviews with each participant lasted between one and two and a half hours. Twenty-seven of the interviews were conducted face to face; when it proved impossible to meet with two participants, I interviewed them by phone. Twenty-three of the interviews took place in participants' offices; one took place in my office, three in cafes, and two in participants' homes. All interviews were tape-recorded; I was the sole interviewer, as well as the sole transcriber of tapes.

All of the interviews followed a consistent format and included standard questions to produce a degree of uniformity across participants. I began each interview by asking participants to describe their professional training, areas of specialization, and years of clinical experience. I then asked them to discuss the mental health services they have delivered as volunteers as well as in their usual clinical settings, and the psychological reactions they have observed in both new and continuing patients, since 9-11. I also asked them to reflect on the multiple ways in which the attack on the World Trade Center has affected them both personally and professionally. In closing the interviews, I asked therapists to consider whether their work in the wake of the attack had altered their views of traditional clinical models, their understandings of psychiatric disorders, their sense of professional competence, or their relationship to the field of mental health.

The interviews were designed to reflect my interdisciplinary orientation. In addition to their standardized portions, they contained open-ended, ethnographic questions to allow critical examinations of therapeutic concepts and assumptions, detailed explorations of participants' personal histories and professional ideologies, and discovery of new topics and perspectives.

Although therapists tend to interpret external events through the lens of individuals' emotional histories, I asked them to consider patients' responses to 9-11 in sociopolitical as well as psychological terms.

The interviews also incorporated some of the methods I use in my clinical work. I explored participants' replies, asked them to consider alternative interpretations and views, and encouraged deeper levels of reflection and self-examination. Having identified myself as a psychotherapist as well as a professor, some participants viewed the interviews as a welcome opportunity to reflect on their clinical work with patients who were wounded by the attack, and to comprehend events that still kept them emotionally off-balance. A few participants who met me in their private offices deliberately seated themselves in the chair that they usually gave to patients, and invited me to sit in the therapist's place. Some recounted their own stories of September 11 in a single unbroken narrative, with a freshness and intensity that suggested that they had rarely told them before. Perhaps because the interviews took place near the first anniversary of September 11, when strong feelings of anxiety, dread and loss resurfaced around the city, or perhaps because participants' stories were uncommonly moving, many interviews aroused strong emotions in participants and myself.

Participants

My research sample was comprised of twenty-nine psychotherapists, all of whom practiced in the New York metropolitan area at the time of the attack on the twin towers. To identify participants who had provided psychological services after September 11, I drew on my extensive contacts in the New York therapeutic community, as well as contacting local trauma centers, psychoanalytic institutes, and psychological and social work organizations. As a result of my outreach, an e-mail was sent to the members of New York State Psychological Association informing them of my research and inviting them to participate. My sample then took shape in a snowball fashion, so that many therapists who were involved in the initial weeks of my research

referred me to colleagues who had done volunteer work, or who had treated individuals in their private practices, after September 11. The time constraints of this project inclined me to select as participants those therapists who were immediately available to be interviewed; at the same time, they discouraged the inclusion of therapists who work in hospitals and social service agencies, where outside research projects undergo lengthy review processes. To discover the broadest range of personal and professional consequences for psychotherapists, my sample included therapists who delivered brief crisis services to survivors and to the families of victims immediately after the attack, as well as therapists who treated them on a long-term basis.

The participants in this research were extremely well trained. Almost evenly split between social workers and psychologists, nearly half of them also had advanced training in psychoanalysis. Approximately half of the participants specialized in the treatment of trauma, and had worked extensively with survivors of war, political torture, crime, domestic violence, sexual and physical abuse, and disasters; one participant had treated persons who survived the 1993 terrorist attack on the World Trade Center. This group was also highly experienced. Of the twenty-eight therapists who had completed their training at the time of this research, the average number of years in practice was twenty-one.

At the time of the interviews, twenty-five participants had private psychotherapy practices. In addition to their practices, some worked on university faculties, in psychoanalytic institutes, in mental health agencies, and in hospitals, and were engaged in professional activities including teaching, research and writing, clinical supervision, administration, and playwriting. Among the four participants who did not have private practices were a school psychologist, a professor of mental health, a therapist in an employee assistance program, and a doctoral candidate in psychology.

In recognition of the racial, ethnic and socioeconomic diversity of New York City, and in response to the substantial literature documenting psychological differences across culture and class (Altman 1995; Carter 1995; Foster et. al. 1996; Roland 1988; Seeley 2000), my sample

included a diverse set of therapists, many of whom work with patients from minority communities. To explore the possibility that the attack on the World Trade Center was perceived differently by various segments of the city, and to begin to sketch out its particular cultural representations, I examined culturally diverse participants' reactions to September 11, as well as the reactions they observed among their patients. While I do not claim that the results of this research can be generalized to all ethnic and racial groups in New York City, or to every member of the groups included here, this research may provide preliminary indications of culture and class-specific patterns of response to the World Trade Center attack. At the same time, it may pose questions for more extensive research on the psychological impact of the attack on specific minority communities.

As a result of my method of selecting participants, and of the scale of this project, my sample is not fully representative. Moreover, while there are distinctions among social workers, psychologists and psychoanalysts, this article refers to participants using the broader and more inclusive categories of "psychotherapists," "therapists," and "mental health professionals." I did not fully control for participants' training, theoretical orientation, or for any other variables. Instead, my intention was to capitalize on participants' unique vantage points, in order to provide new kinds of data on the psychological impact of September on psychotherapists, and to suggest directions for future research. Before proceeding to the findings of this research, I should state that in order to maintain the confidentiality of the participants in this research, and of the patients they describe, all identifying information has been changed.

FINDINGS

Many participants in this research stated that their work in the aftermath of the attack on the twin towers was the most difficult they had ever done. This section describes the specific personal and professional challenges New York metropolitan area therapists faced in providing mental health services following September 11. After examining the lack of appropriate clinical

models and diagnostic categories, and the increased demand for mental health treatment, this article explores how therapists delivering psychological services in a range of clinical settings over the past fourteen months have been affected by their work.

Treating the unspeakable

In a profession that places the highest value on saying the unsayable, after September 11, psychotherapists, uncharacteristically, were at a loss for words. Confronted with "a level of violence that is, literally, unspeakable," and with events that, to this day, are referred to by numerals rather than names, they have acknowledged the impossibility of verbalizing

> "our loss, the attack, the disaster, the catastrophe, the act of war, what should we call it (Dimen 2002:451)?"

Just as the events of September 11 have proven impossible to name, many participants who were eager to help after 9-11 were uncertain what, and whom, they would be treating. How is it possible to provide psychological help to persons suffering from that which cannot be named? And how should the sufferers themselves be identified? Therapists struggled to classify these events, and to label those who had been harmed by them. To some participants, they were survivors of a disaster, like people who lost everything to hurricanes and floods. To others, they were families of crime victims, like those who lost loved ones to manslaughter or murder. While some participants believed that the mental health sequelae of September 11 defied psychiatric categorization, others diagnosed individuals who had experienced vivid flashbacks, intrusive memories, hypervigilance, and recurrent nightmares since the attack with posttraumatic stress disorder (PTSD).

To date, trauma is the term most commonly used to refer to the psychological consequences of the attack on the World Trade Center. For some participants, trauma has become the accepted label because

"trauma has to do with experiencing something horrific that never should happen to you…that's just inconceivable."

Trauma may also have become the accepted label because the word has colloquial as well as medical meanings. It is possible to describe someone as "traumatized" without invoking the severe symptomatology that is specific to PTSD (American Psychiatric Association 2000). Yet even when participants agreed that PTSD was the appropriate diagnosis for many who survived the World Trade Center attack, they did not agree how it should be treated. Indeed, there is a lack of consensus among mental health professionals on the most effective clinical interventions for PTSD (Ballenger et. al. 2002).

The prominence of trauma in the discourse of mental health since September 11 reflects recent shifts in clinical theory and training. Several participants who were trained prior to the early 1980s said they were never taught about trauma, and in many contemporary clinical programs, training in PTSD remains peripheral. Moreover, some of the basic principles of trauma treatment conflict with those of traditional therapeutic approaches, creating divisions among various kinds of clinical specialists. Therapists who are otherwise highly trained and experienced may be untrained in, and dismissive of, specialized treatments for trauma, while trauma specialists claim that traditional therapeutic approaches can exacerbate the symptoms of PTSD.

Although many participants felt their lack of formal clinical preparation very keenly after September 11, they did not let it interfere with their wish to help. Several described themselves as "tough" or "level-headed" or "effective in crisis," suggesting that even if they were untrained in trauma, their personal characteristics qualified them to intervene. Other participants sought to acquire a new therapeutic expertise as quickly as possible. They surfed the internet for information on treating survivors of disasters, exchanged articles with peers on the Oklahoma City bombing, and took crash courses in trauma to augment their clinical skills. In spite of their efforts, after the attack many participants found themselves delivering services they had never been

trained to provide, to populations they had never been trained to treat, in situations where they had never been trained to work. As one participant said,

> "Nobody had even had one course on debriefing. Disaster was not anything anybody had ever been taught."

Even participants with related clinical training and experience felt unprepared to treat persons deeply wounded by September 11. Those who specialized in disasters, such as earthquakes, hurricanes and airplane crashes, were unsure how to help victims of an unanticipated, incomprehensible, and terrifying act of war. Those who specialized in treating individuals with traumatic histories, including Viet Nam veterans, victims of torture, and survivors of abuse, had little idea how to treat persons suffering from a current traumatic event. Those who specialized in bereavement had not been trained to help persons whose relatives were killed by terrorists, or whose losses could be counted in dozens, or who had lost their entire relational world. One participant said,

> "I hadn't really dealt with someone that lost fifteen people, and his best friends, and his whole peer group."

A second participant described a patient who "lost 61 of his colleagues and his best friend." A third spoke of working with firefighters who "knew 100 people who were dead."

Struggling to comfort the terrorized, the disoriented, the numbed and the bereaved, participants had little sense of what do to do. "None of the old models worked," one participant said. "We were just going by the seat of our pants."

Psychological first aid

The need to "make it up as we went along" was especially common among therapists who volunteered their services in the first few hours and days after the attack. As the magnitude of the damage became clear, many participants, desperate to help, contacted the Red Cross. But New York City airports, bridges and tunnels were closed on September 11. National Red Cross

leaders, including the most experienced disaster responders, could not get into town for several days. Numerous participants who went to the New York City chapter of the Red Cross to volunteer described the local office as chaotic and disorganized. One participant remarked that "they had far too many therapists, and they didn't have a clue how to use them." Another participant said that he and his colleagues were told by the Red Cross to "figure it out for ourselves."

In the absence of an organized mental health response in the early days after the attack, many therapists took it upon themselves to find a way to help. Rather than waiting for the wounded to come to them, they searched for people in need of psychological first aid. All over the city, therapists improvised. A psychoanalytic institute in Greenwich Village opened its doors to the public, offering free group treatment. A few therapists set up tables in their Brooklyn neighborhood, providing passersby with literature on trauma and referrals for psychotherapy. Some participants enjoyed the freedom of reaching out to their communities in unconventional ways; it took them back to their professional roots. In the words of one participant,

> "You felt right away like it was 1890, and you were a charitable organization social worker, and you had to go door to door…we were out there."

Other participants found being "out there" less gratifying. Though hundreds of thousands of people were believed to be in acute distress, therapists could not always find them. One participant described going from one location to another with several colleagues on September 11, frantically searching for people to help. Immediately after the attack they had gone to the Red Cross, where they were put on a bus and sent to the World Trade Center. But after access to the site was restricted, the Red Cross redirected the bus to Penn Station, where they expected to find commuters who were injured, in shock, and trying to get home. This participant and his colleagues learned to identify World Trade Center survivors by looking down at their feet, because those who escaped had white dust on their shoes. However, going to Penn Station

> "turned out to be a waste of time, because the people who survived fled within the first 20 to 30 minutes, and they were long gone. They walked over bridges or hopped on a truck or ferry or whatever they could to get out. No one relied on traditional transportation, so Penn Station was virtually empty."

Frustrated that the Red Cross had failed to connect them with the wounded, he and his colleagues decided that they would no longer take their direction.

> "We lost all contact with them. So we're acting like we're under the auspices of the Red Cross, but frankly, it just gained us admittance."

After an unsuccessful attempt "to wrestle down an ambulance to bring us to the Trade Center," they walked from hospital to hospital offering their services. They finally found a small hospital whose emergency medical workers had been wounded at the twin towers, and whose director asked them to work with his staff.

When therapists did find people to help, their interventions were not always appreciated. One participant told of walking into her neighborhood fire department, which had been among the first responders to the attack, and offering her services.

> "We sat down and literally ran a group with a lot of guys that were in shock, a lot of PTSD…they were in bad shape, they were crying, they were numb, they were flashing back."

In this participant's professional assessment, the firefighters were unfit for active duty—as she put it, "I wouldn't want them responding to my fire"—and she counseled them to take time off to recover. Her advice was rejected by the firehouse lieutenant, who told her,

> "you don't understand. We can't put them on leave, they have to go back. We don't have anybody here. They have to go back."

Many therapists who eagerly volunteered had little idea how to deliver their services. Sent to work at various relief sites set up throughout the city, they found themselves amidst human misery and devastation on an unimaginable scale. There were "thousands and thousands of

people with thousands of needs"; the poor and the wealthy stood on together line for hours, often in great anger and distress, to tell relief workers,

> "'I'm living on the streets, I'm stuck. I have lost all of my papers, I have lost everything, all of my identity in the World Trade Center'. Or 'I was stuck in an elevator'. Or 'I got down the stairs, and now I can't breathe…Can you give me $500, can you get me a hotel room, can you help me with my creditors, I have no apartment, I can't get into my apartment in Battery Park City…'"

Therapists quickly learned that their usual ways of practicing could not be implemented in these circumstances. As one participant remarked,

> "You suspend all that you've ever learned about how to be in the perfect setting with the two chairs properly placed and the pristine office with the box of tissues available."

One participant recalled trying to figure out how she could help people waiting on line in a Family Assistance Center, and how she should approach them. She decided

> "that you should just work the room, which is not what any of us are trained to do…In this case, I just worked the waiting room. I just went from one person to another to another to another to another to another, and I would talk to 30 people in the course of four hours. And if anybody was really breaking down, or saying things that were too much for other people to handle, or talking too loud…you would pull them aside."

Others who volunteered their services were sent to Ground Zero, to work in settings below military checkpoints that felt like war zones and "looked like the embodiment of anguish." But many therapists, who had been sent to help rescue and recovery workers, were themselves disoriented, dazed, and "couldn't take it in; it was in some ways like watching a movie." One participant described eight-hour shifts, lasting from four in the afternoon until midnight, in a respite center set in a condemned hotel, where "everything was covered with plastic--the walls, the floors everything." The overpowering "smell of death" gave her the sense of "being in this biological stew," and her shifts were punctuated by

> "Catholic priests rushing in and throwing on Red Cross jackets and rushing out, so you'd know they'd found a body or body parts."

Therapists, who were expected to make contact with the workers in this public setting--"to just sit down and talk with them"--seated themselves in dining areas where rescue workers came to eat during their breaks. It was clear to several participants that many workers, whose twelve-hours shifts were devoted not only to clearing debris, but to locating the bodies of colleagues and friends, were "losing it"; they were sobbing, looking glazed and unresponsive, and "self-medicating like nobody's business." Yet participants, who recognized that their overtures might not be wanted, were uncertain how to respond.

> "It was a delicate situation [because] some people just did not want to talk with anybody and others really wanted to talk. So you had to be really careful about how you approached people so you didn't become a pain in the neck on the one hand, on the other hand, you were available if somebody needed you."

They also realized that the rescue workers could not afford to connect with them on an emotional level during their breaks, because

> "they all had to go back to work…They had to go back out onto the pile or into the pit. They were really in shock, and they were just going, going, going, driving themselves."

When their shifts were over, after walking through the "absolute muck," of the site, therapists would arrive at the washing point,

> "where the guy washes off your shoes with water. I'm thinking, I've just walked through toxic material. Are we both gonna participate in this fiction that my shoes have just been made clean with water from a hose?"

After washing the dust off their shoes, participants returned to the rest of their lives. They tried, with mixed results, to get the dust and the smell of Ground Zero off of their bodies, out of their clothes, and out of their apartments. They also tried to control the images of Ground Zero in their minds. But

> "then the next day, while I'm trying to teach, while I'm trying to make sense of it, while I'm trying to deal with students, while I'm trying to do whatever, then those guys would pop into my mind."

Faces of the bereaved, the displaced, the injured, and the recovery workers, images of the Armory, the Family Service Centers, and the World Trade Center site, and fragments of conversations stayed with them. At the time of the interviews, some participants—especially those who were used to seeing their patients every day or every week, for periods of months or years--still worried about the people they had spoken with for a few minutes, in states of profound emergency, desperation, grief and fatigue, and had never seen again.

"Get me counselors!"

As psychotherapists confronted a variety of unfamiliar, urgent, and extreme situations in the wake of the attack on the World Trade Center--situations to which standard clinical models did not readily apply--the demand for mental health services grew. The New York State and United States governments stoked this demand. Indeed, in the eyes of many New York psychotherapists, another unusual consequence of September 11 was that these governments strongly endorsed mental health services as legitimate and effective remedies for the emotional suffering this violent catastrophe produced. Government officials publicly acknowledged mental illnesses such as posttraumatic stress disorder and depression, provided moneys to educate the public about them, and supplied an array of psychological services to treat them. Mental health was firmly identified as a key component of public health. For psychotherapists, this came as a rare public validation of their services and skills. Following many discouraging years in which psychotherapy had been deprived of insurance coverage, displaced by psychopharmacology, and generally derided, after September 11, New Yorkers in distress were advised to get themselves to a therapist.

Favorable economic factors supported the influx of new psychotherapy patients. Many Project Liberty mental health services were made available free of charge to persons upset by the

terrorist attack. Moreover, those employed in the World Trade Center and in its vicinity had relatively high rates of private insurance, which included coverage for mental health treatment. In cases where the primary policyholder died in the attack, many insurance companies agreed to continue covering family members for several years (Jack & Glied 2002). Despite financial losses immediately after the attack, when offices in the "frozen zone" below 14th Street were inaccessible, when some therapists closed their practices to work as unpaid volunteers, or when some patients refused to travel to Manhattan for their appointments, after 9-11, several participants said that their telephone "never stopped ringing." As one participant asked, "Was there ever a time when everyone in New York City wanted treatment? "

The demand for mental health services came not only from individuals, but from organizations of all kinds. Participants who worked in educational institutions, and who had previously offered psychological treatment primarily to students, encountered new requests for help from administration, faculty, and staff. Many downtown firms were devastated by the attack. Staff members had seen the towers fall, or watched people jump from the towers, or climbed over bodies as they fled, or been trapped in clouds of dust, or walked miles in states of terror, or been displaced from homes or offices, or lost colleagues and close friends. Several participants were hired by corporations to debrief employees who were terrified, numb, and had no interest in their work. One participant estimated that a large corporation that had lost hundreds of employees on September 11 "had 3,000 people in acute stress disorder." Some participants mentioned human resource managers whose true concerns for employees' wellbeing were equaled by their need to get them back to work quickly, so that their businesses would survive. In many cases, therapists were expected to be available immediately, and to provide large-scale relief instantaneously, often on a voluntary basis. One participant recalled a human resource manager for a particularly devastated firm commanding her, "I want thirty therapists on the thirty floors of our building prepared to give counseling twelve hours a day for a month!" All over town, this participant said, managers were shouting, "Get me counselors!"

Several strategies were implemented to meet the urgent demand for mental health treatment. Mental health organizations and psychoanalytic institutes compiled lists of therapists who wished to donate their services, and sent them to sites in need of them. Therapists rushed to organize conferences on disaster mental health, and to be trained in working with survivors of trauma; one participant, a trauma specialist, gave sixty colleagues a crash course on trauma the week after 9-11. Some mental health organizations hired additional therapists; others brought in experts from Oklahoma City or Israel to instruct their staffs in the psychological effects of terrorism.

While these strategies often worked smoothly, at times they engendered competition and resentment. Therapists who gave up income from their private practices to volunteer their services, as well as therapists who were paid their usual wages in extraordinarily demanding situations, worked next to highly paid, and newly hired, mental health consultants. Some participants felt pressured by their institutions to provide pro bono services when they couldn't afford to, or to provide services they were not trained to deliver, to one traumatized group after another.

> "It was, 'you're doing debriefing on Monday, and you're doing debriefing on Wednesday, and you're doing debriefing on whatever, and can you also do debriefing here, and can you do debriefing there?'"

Service delivery could be disorganized with "too many therapists competing" to provide help at the same location, so that "I would go and actually nobody would show…because there was no need for more debriefings." Some therapists who volunteered their help were firmly turned away. According to one participant, whose school had rejected numerous offers of help from outside therapists, such offers "didn't inspire much confidence"; in his view, mental health professionals "were ready to move in with their own agenda" rather than respecting the needs of his community.

Many therapists were working overtime. Some who volunteered at Ground Zero into the autumn months worked their eight to twelve hour shifts at night, and their regular jobs during the

day. One participant shuttled between the World Trade Center site and her private office uptown, and said that if she planned it right,

> "I could get back here and get a couple of hours of sleep before I sort of tumbled into the next day…throw water on my face, and not look, or smell, like I had just come from there."

A participant who worked three hours a week at a downtown school before September 11 was suddenly working thirty. Another participant asked a friend to buy and send her new clothes, because she was "working nonstop; breakfast, lunch, dinner, we were here seven days a week."

Therapists with private practices, especially specialists in trauma and bereavement, were flooded with referrals for prospective patients. Some enlarged their practices, and offered free therapy to those emotionally injured by the attack who could not afford treatment. In explaining their availability, participants frequently mentioned a sense of obligation.

> "I felt it was my duty since I was a bereavement therapist to be available after 9-11 for whomever I needed to be available for...The first month I was available for nothing for anybody who needed to talk about it. About November, December, my phone never stopped ringing."

Others simply saw themselves as the most qualified for the task at hand. As one participant said, "This is my specialty. If I don't do this, who's gonna do it?"

Emotional contagion

While psychotherapists struggled with a variety of professional challenges in the post September 11 clinical landscape, the majority of participants in this research reported that the emotional aspects of their work were the most profoundly challenging. Though they made themselves available to survivors of the attack, and to families of victims, many did so at their own emotional expense. Participants linked their emotional vulnerability to the deep, empathic, and intimate connections between therapists and patients that psychotherapy requires. One

participant described herself and her patients as "psyches in conversation." Another explained that psychotherapy entailed entering the patient's subjective world.

> "In my training, I was really taught to let myself be drawn in and then to fight my way out. That you can't really understand what your patient is feeling unless you allow yourself to be drawn into that subjectivity. And then the work of the therapy is really to pull yourself back and come out and look at it in a much more objective way."

But many participants described a new inability to pull themselves out of their patients' subjective worlds. Specialists in treating the traumatized and the bereaved noted that although they recognize that their own emotional stability depends on limiting the number of severely distressed patients they see, they abandoned such considerations after 9-11. Since the attack, their practices have been filled with greater numbers of "horror cases"—of persons profoundly devastated by an unimaginably violent and agonizing catastrophe. As a result, one participant said that,

> "For me, almost every day is death and destruction and grief and abject pain…it's like hours every day."

Many participants, uncertain how much tragedy they could cope with, felt pushed beyond their professional capacities. Unable to take refuge in the "protective coma" (Didion 2003:54) that shielded so many others, they struggled to remain emotionally present several hours a day, for weeks and months on end, to patients whose stories were among the most painful and gruesome they had ever heard. Many spoke of being dazed, exhausted and numb; of spending days in their offices, where they would help patients voice their stories—where they would "let her talk and listen to her, and listen to her, and listen to her"—and nights at home in tears.

While several participants reported that after 9-11, they had cried in front of their patients for the first time, others mentioned how important it was for them to maintain their composure in clinical sessions;

> "to be able to look somebody right in the eye and let them tell you about the atrocities and the devastation and not flinch."

One participant described a patient's reaction when a Red Cross worker broke down after hearing his story.

> "All he kept saying [was], 'I made the Red Cross lady cry, I made the Red Cross lady cry. I must be really bad because I made the Red Cross lady cry.' I wanted to find this Red Cross lady…her crying traumatized this guy."

The most wrenching clinical situations psychotherapists faced after 9-11 concerned the missing and the deceased. Some participants discussed their confusion in offering hope to persons whose relatives were missing, sometimes encouraging their search for them at one hospital after another, though they themselves believed that no one had survived the towers' collapse.

> "I would have family members who would come in a week later, three weeks later, still carrying photos, and say, 'Have you seen my family member?' And I would have to say 'no.' And they would come back again until they would say, 'Well, I guess that is not the case.' And I'd say, 'Well…you may be right.'"

Others said that they were given lists of the dead to share with the families of the missing; because the lists were not always accurate, however, they had sometimes unwittingly misinformed family members. Two participants lost patients in the attack. One who worked with uniformed services personnel at Ground Zero recalled looking down into the site and wondering, "Is my patient down in there? Are they gonna find him?" Another participant reported that a patient who had lost dozens of friends in the attack had phoned her one morning to say that he was about to jump onto the subway tracks, and to ask her why he shouldn't.

Some participants suffered from their new acquaintance with the dead. A participant who worked with numerous family members of the deceased said that she had begun to feel "inhabited" by the dead.

> "I'm getting to know the people who died extremely well through the people who are talking about them.…I find myself looking at the pictures [in the newspaper] of the people that I know through the people I'm working with and saying, oh, so that's what you look like…And I find myself wondering the kind of things that their grievers are wondering. Did you suffer? Were you panicking? What was it like for you in the last few minutes?"

Several participants described the anguish produced by a situation of mass slaughter lacking the usual proofs of demise, so that the death of a particular individual could not be ascertained. Even when a relative's death was established or accepted, their families could not make use of standard mourning rituals, or grieve in conventional ways, because there was often no body to bury. Many families had received fragments of bodies, and had been told that more pieces would come.

> "So the word is out among family members that you will get more of your son, of your daughter. And the families say, 'What are we gong to do? Have another memorial service? Are we gonna dig up what we buried?'"

Participants who listened as their patients discussed people on fire, or bodies falling from windows, or fragments of tissue, or body parts in the debris, spoke of how difficult it was for them to visualize what was described to them in sessions.

> "I'm a very visual person. So I am knocked to the fucking floor. And I am stuck in the elevator, and I am choking down the stairs and tripping over something and losing my briefcase…it's all very vivid…and it was a lot to carry around."

Another participant said that she'd always had "videotapes in my head" of patients' sessions.

> "When somebody comes in and sits on the couch, I pull out the videotape, I put it in, and I automatically see their whole life. I see all their boyfriends, I see their aunts and uncles and them as a little kid… So all this horror shit is in my head, visually."

Though many therapists tried to control their own anxieties by shutting out the media, their patients brought them information and rumor, along with their idiosyncratic terrors. As they

listened to patients' stories in the weeks and months after September 11, participants absorbed not only their anguish, but also their fears.

> "I found myself becoming much more anxious when I had certain patients coming in talking about their theories, and talking about how they would only ride on the front of the train or the back of the train, because a bomber wouldn't go to those cars. Or how they would kill themselves if a nuclear blast went off, cause they didn't want to die of radiation poisoning. Listening to their thought process, I could feel myself becoming much more anxious than I would have if I hadn't heard it."

Many therapists noted that they had never been so affected by their patients' psychological symptoms. One participant remarked, "If I'm treating an alcoholic, I'm not gonna start drinking." But 9-11 was different. As another participant said, "there wasn't one of us there that wasn't hearing it and taking it on."

Simultaneous trauma

The communal nature of the catastrophic attack on the World Trade Center heightened the transmission of psychological symptoms and emotional distress from patient to therapist. Contrary to conventional conceptualizations of mental disturbance as individually located and owned, the attack's psychological repercussions were shared both within and across communities, and spread as if contagious. September 11 was not a collective trauma in the sense that it damaged the bonds of community (Erikson 1995), but in the sense that it was experienced communally. In the words of one participant,

> "The experience, the visceral, psychic mind-heart continuum experience, was a collective experience. We all reacted out of a collective archetypal knowledge of survival and dread…That level of communal experience outweighed the personal story."

Another referred to the collective nervous system that was damaged by the attack.

"Everybody's trauma was so raw…It didn't matter who you were talking to, relief worker, direct victim, other therapists—you were all the same body in some ways."

This injured social body manifested itself in the clinical consulting room. In the immediate aftermath of the attack, patients' individual identities and idiosyncratic body languages seemed to have been erased.

"The first week or so, people just sat. They just sat. You know, I had somebody who always sits like this, with her feet in the chair, and she was just sitting [slumps]. For the first week or two, somatically, people were just here."

Not only was this trauma collective, but it was experienced simultaneously by therapists and their patients. Some participants had family members who were injured, or personal property that was damaged, in the attack. Others witnessed the attack from their offices, or rushed to retrieve their children from school, or spent hours in a state of panic because they had not heard from friends or relatives who worked in the towers. Several participants said that they thought they were going to die. This simultaneous trauma produced an extremely rare clinical situation in which therapists were shaken and hurt by the same catastrophic event as the patients they were treating. For some participants, this meant that

"We all kind of were in the same world in a way that we hadn't been…When a patient would say to me, "that smoke, the smell of that smoke"-- I smelled it, it was in my lungs. We couldn't pretend that she had to tell me what that was."

This simultaneous trauma also produced a clinical situation in which therapists, who in theory have worked through their psychological conflicts and anxieties, were trying to help patients while their own wounds and fears were still raw. Some participants saw themselves in their patients' devastation, and seemed comforted by patients who voiced feelings that they shared. One participant said, "So many times I've been in session, and I want to say, 'Me too! Me too!'"

Indeed, the events of 9-11 blurred therapeutic boundaries in several ways. For some participants, the fact that they and their patients were stricken by the very same attack meant that

the usual distinction between the therapist and patient—perhaps the most important distinction in psychological treatment—no longer held. As one participant said,

> "If you're my patient and you've been through this, and I've been through it, and I'm calling you sick, then I'm sick too."

Many participants found it more difficult than usual to separate their lives from their patients' lives. They continually had to remind themselves, "This is your life. Your husband isn't dead, your kids aren't dead. You're okay." One participant said that after working for several months with families who had lost children, and who had told her of their last words to them, she was "hounded" by the fact that whenever she saw her son,

> "If he said goodbye in a particular way…I'd be going, oh jeez, the way he said that, something is surely going to happen. That was significant, that was different than the way he usually said that."

Many participants noted the irony of providing mental health treatment to others when they felt sorely in need of it. Some returned to treatment, while others imagined giving up their professional role.

> "You don't want to be the therapist….the one who couldn't cry, who had to know what to do….What happens if I couldn't cope?…I don't want everybody depending on me."

Traumatic memories

Participants in this research tended to interpret patients' emotional reactions to the attack on the World Trade Center through their usual clinical frameworks; that is, they understood individuals' reactions to the terrorist attack in terms of their distinctive psychological histories. Participants expected the attack to arouse patients' most disturbing feelings and memories, and to retraumatize those with prior experiences of violence or abuse. As one participant explained, because external events resonate internally with each person in particular ways, in treating patients after the attack, she tried to understand

"how the reality of what we all know is going on dredged up old feelings of being unsafe, or old feelings of being vulnerable."

Although participants expected the attack to trigger disturbing feelings and memories in their patients, many were not prepared for the traumatic memories it awakened in them. Several participants said they were caught off guard when they began to re-experience agonizing parts of their personal histories after September 11. Like their patients, participants found themselves upended not only by the violent assault on their city, and by the continuing climate of danger, but by vivid memories of degradation and despair. One participant saw clear visual images of a traumatic injury he sustained as a one and a half year-old child, memories that had not surfaced during his lengthy psychoanalysis. Another remembered forgotten aspects of his mother, so that he had to mourn her again. A third, who stood on the sidewalk watching the towers burn and collapse, recalled watching her "whole city" burn in Japan during World War II. A fourth, who saw Project Liberty exclude mental health professionals of color from positions of responsibility, relived experiences of racial discrimination. In the weeks after 9-11, when newly installed security guards asked her for identification, she wondered,

"Do you do this to other people? Or is it just because I'm a black African-American woman?"

Cultural transferences

While some participants confronted historically devalued racial identities after September 11, others had to contend with newly problematic cultural identities. Heightened public suspicions of Arabs and Muslims extended to psychotherapists; those who were of color, who were foreign, or who spoke English as a second language, were suddenly located and named. Participants from the Middle East and South Asia reported that some patients began to mistrust them.

"People can suspect…that I could be from some other part of the world…Could I be like these hated fanatics?…Am I one of them? And am I safe? Who am I?"

The suspicions of newly fearful patients materialized in the stories they told their therapists.

> "The patient started to talk about the fact that the other day some U-Haul trucks were stolen by some unknown Arabs, and they were dangerously running around the country with explosives, and there might be attacks. And I could see that in many ways there are concerns about me, that can I be trusted or am I one of these dangerous Arabs with powerful explosives running around in the street?"

Though participants worried that this cultural stigma would intensify, rather than taking patients' mistrust at face value, they analyzed its psychological meanings. In almost all cases, even patients who had grown more wary of their therapists chose to stay in treatment.

The underserved

Unlike participants whose cultural identities became highly visible after the attack, many minority groups remained invisible. Though Project Liberty's mental health programs were said to have reached "non-white, non-English-speaking groups at rates proportional to their representation in the general population of the disaster area" (Felton 2002:432), in the view of some participants, these programs were neither available to, nor culturally appropriate for, various communities. As a result, after September 11, a variety of groups did not receive sufficient help. According to participants, underserved groups included the elderly, some of whom "were so terrified that they were not coming out of their apartments"; illegal immigrants and undocumented workers, who feared they would be deported if they applied for relief; Latinos, whose responses to the attack often were exacerbated by poverty, discrimination and by the crash of flight 587 in November; African-Americans, some of whom did not seek help to avoid being seen as "just want[ing] handouts"; and the gay community, whose surviving partners were ineligible for a variety of benefits, and whose invisibility reached new heights. One participant said that although gay people "were out there helping; firemen, policemen, whatever," their contributions were not publicly acknowledged. This participant ran a group for the surviving partners of gays and

lesbians who died in the attack. She recalled a session in which they had read the New York Times "Portraits of Grief" obituary of the partner of one of its members; the couple had been together for twenty years. As the obituary was read aloud,

> "we all thought we would die, cause…it said something to the effect of, he was so busy with his work, he wasn't interested in having a relationship."

Several participants noted that the social hierarchy was reproduced after the attack on the World Trade Center, complete with glaring disparities. Some experienced these disparities firsthand. One participant of color said that although her employer sent "very affluent" staff members to debrief employees of prestigious corporations, they sent her to help the poor; and that although her employer expected her to volunteer her services after September 11, they requested that she stop her work with the Dominican community after the crash of flight 587. Other participants confronted these disparities through their patients' reactions to the attack. Some described patients who live in neighborhoods filled with violence and devastation, or who have lengthy histories of trauma, who were "already living in hell" prior to the attack, and felt unmoved by it. These patients deeply resented the outpouring of money and support for victims of September 11. For others who are socially disenfranchised, the attack on the World Trade Center

> "symbolized that American power was attacked. And American power, that power establishment, they didn't have any sympathy for."

Many participants worked overtime to reach out to these communities in the wake of September 11. In addition to their usual professional responsibilities, and to their work as volunteers, they made efforts to locate bilingual therapists, design culturally appropriate services, establish social supports for illegal immigrants, and find legal aid for undocumented workers and detainees.

The Florence Nightingales of the world

As therapists served the wounded and the bereaved, they themselves had little relief. At the time of these interviews, which were conducted more than a year after September 11, 2001, many participants said that they had not had time to mourn the attack on the twin towers. One participant said that in the first few days following the attack, when

> "the rest of the country was gathering with family and friends and going to vigils and grieving this whole thing, and we were just here working."

One particular evening when she was working late, she and a colleague heard noise from the street. They looked out their office window,

> "and the whole street was filled with people holding candles…And it was like, it's nice that everybody's doing this, but we have a department to take care of …You worry about yourself later."

Though many participants felt supported and soothed by their peers, others found no one with whom they could discuss their work. Lacking adequate professional supervision, and noting that "you're not doing work that can be "share[d] at the dinner table," they refrained from exposing others to the horrific stories they heard every day, for fear of spreading the damage. As a result, while psychotherapists were taking care of the city, no one was taking care of psychotherapists. One participant said, "It almost like we didn't count. We were just the Florence Nightingales of the world."

Without proper care, many therapists suffered. Several participants could not eat or sleep, and had nightmares and flashbacks; others were numb or depressed, and grew irritable and withdrawn. Some participants were frustrated by patients who didn't recover, and impatient with others whose complaints were mundane. Almost all of them had difficulty leaving their work behind when they went home. After spending the day with patients,

"I couldn't listen to anything else. I didn't want anybody else stressing me out. I could not listen to other people's problems. I just wanted to do my patients and listen to the families who were going through this trauma. And that's what I did for a year."

Some worried that they had pushed themselves to work overtime to avoid facing their own emotional responses to the attack.

"Have I become one of the firemen who won't quit digging, because if you quit then you've got to deal with what's going on?"

One participant who was pregnant on September 11 worried that her constant crying would harm her baby. Another wondered how her clinical work with firefighters would affect her in the future.

"In ten years, I could be some specialist who goes and talks all over the world about this kind of stuff if that's what I wanted. I like to think about myself doing that more than being curled up in a ball somewhere, unable to go to work."

Lacking institutionalized means of support, participants found various ways to care for themselves. Some went into psychotherapy to understand how the attack had affected them both as individuals, and as providers of mental health treatment. Others cut back their schedules, and saw fewer patients in a day. Some took refuge in spiritual practices, or in private rituals that cleansed them of the toxins they absorbed when they listened to their patients; others felt strengthened by their patients' bravery. Some fortified themselves professionally, taking every training they could find in trauma and catastrophe. One put her financial affairs in order and made plans for her family to escape the country in the event of another attack.

Paradigm shifts

If the attack on the World Trade Center signified a breaking of national boundaries, for many therapists it also signified a rupture of clinical boundaries. In response they modified their usual modes of practice, frequently abandoning the orthodoxies of their training. Inspired by the

unconventional therapies they delivered as volunteers, some determined “to do anything and everything, in any way you can” in the name of mental health.

Many participants noted that the boundary between therapist and patient was broken by September 11.

> “We crossed a line, because there was no line anymore. We were in it with everyone else.”

While some were uncomfortable without the line, and sought to reinstate it as quickly as possible, several participants welcomed the lack of distance and separation between themselves and their patients, saying that it made them more emotionally honest and involved.

Other participants noted that the attack on the twin towers ruptured the boundary between the world outside the consulting room and the world within it. The therapeutic space had been breached, and was no longer protective or safe. Some participants who previously had focused their work on patients’ inner life felt the attack forced them “out of the safety of the symbolic world, into the real.” After September 11, they also felt that they had to keep “an eye toward the outside all the time.” Hearing the sounds of airplanes and sirens—sounds which were no longer routine—one participant interrupted sessions to turn on the radio, or to look out the window, to make sure that the real world was intact.

After the attack on the twin towers, however, who was to say what was real? Following an event that a number of participants described as cinematic and surreal—as one said, as if “we’re all living in a dream”— and that actualized their patients’ most violent fantasies, many participants no longer felt qualified to speak on behalf of either the rational or the real. How could therapists distinguish patients’ paranoid thinking from logical reasoning, or assure them that the world was safe? In the eyes of some participants, patients’ constant fears of danger and assault suddenly seemed more accurate than their “irrational” sense of stability.

In another clinical shift, for many participants, the attack moved the focus of psychotherapy from patients’ past to their present. After September 11, patients who spoke of

their childhood were likely to be seen as avoiding their feelings about the attack and the newly menacing present. With the future put into question, some participants approached their work with a new sense of urgency. One said that since the attack, she had begun to be more directive with her patients, and to help them to make changes in their life more quickly.

> "[I'm] trying to help people figure out what's important to them, and to do whatever it is that they need to be doing. I try to help people speed it up a little."

More importantly, as the year after September 11 wore on, several participants began to reconsider the fundamental nature and purpose of their work. Some began to view patients' responses to the attack not as symptoms of mental illness or of psychological disorder, but as an intractable element of the human condition. Accordingly, they questioned the utility of analysis, as well as their ability to help patients recover.

> "I'm much more inclined now…to see the kinds of human suffering that life contains as part of what life contains, and that it doesn't need to be fixed. It's not comfortable, it's not terrific, but life is filled with suffering…Ultimately, life cannot be fixed."

It is impossible to say whether such paradigmatic shifts will endure. Yet at the time of these interviews, many participants expressed little interest in restoring the traditional therapist's role or conventional modes of practice.

Long distance runners

While there is little information on the long-term psychological consequences of terrorism, this research suggests that its impact is ongoing, and in some cases, may be widening. In the fourteen months since the attack, participants had observed a broad range of responses in their patients. Some patients had recovered, and their work and relationships were sound. Some, paradoxically, felt healed by an act of horror that normalized a personal history of violence, or that trivialized a private misery. In contrast, more than a year later, some patients still had not discussed what they saw on September 11. Those who had realized the depths of their wounds

only recently had finally told their stories. Still others, unaware of their motivations, had become self-destructive.

Many survivors of the attack, as well as the families of the deceased, still feel its grip on their lives. As one participant noted,

> "each landmark brings another ripple. Each holiday brings up more memories and more side effects."

For many patients, especially those who lost family members in the attack, it's as if September 11 was yesterday. One participant said,

> "I have people who come into my office and sit down, and I say how are you doing? And they say, 'Well, you asked me that on November 1 [2001], and that's how I'm doing…. I'm still right there where I was. I'm still watching the plane on television hit my son.'"

A year after the attack, many participants began to see a "second tier" of patients composed of victims' and survivors' distant relatives and acquaintances. The second tier also includes the families of recovery workers. Their spouses are especially fearful of trauma's spread into their homes; some worry that their husband's work clothes will bring "all the chemicals and the poisons and the jet fuel fumes in the house to poison the baby."

Several participants were surprised to find that after a year, the attack on the World Trade Center was still the focus of their work.

> "You think it's gonna end…or that the clients that are coming in are gonna come in for other things. But that's not what's happening."

They were also surprised that their clinical work had a new, intermittent, quality, and that the treatments they delivered seemed never to end.

> "Where in the past you finish with someone…here you never do. People keep coming back for more help."

Some participants reported that after a year, their work with relatives of the dead had become even more difficult. Rather than beginning to recover,

> "People are really starting to feel their sadness. They're really processing that he's not coming back, or she's not coming back, or I'm never gonna see him again…The real suffering part is happening this year."

If the report of a participant who treated a woman injured in the 1993 bombing of the World Trade Center is any indication, their suffering will continue indefinitely. Like many 2001 World Trade Center survivors, this patient's psychological trauma was exacerbated by the physical wounds she suffered in escaping from the towers. The participant witnessed her patient's life "disintegrate" during her seven-year psychotherapy. Too traumatized to return to work at the World Trade Center--indeed, too injured to return to work at all—her personal identity was shattered. Her marriage deteriorated, and "her husband became an old man." The patient's psychotherapy, which began shortly after the bombing, ended with her death from complications of her injuries.

Anticipating agonizing and protracted psychotherapies with patients profoundly damaged on September 11, some participants sought to pace themselves.

> "I feel like I've got to be a long distance runner here… I feel like I'm gonna be best for them if I can be the slow and steady and predictable and permanent presence for as long as they choose to be here."

In the face of such daunting work, one participant renewed her commitment to the mental health profession. For her, it was the only way she could be of service in a time of national crisis.

> "All I can do is keep doing what I'm doing. I can't go dig, I have a bad back. I don't know how to fly a plane, I don't know how to carry a gun. [But] I can talk to people. I can try to help them. I can cheer them up. I can help them cry. I can hold their hands."

Psychological healing

The sections above detail the numerous difficulties participants encountered as they delivered mental health services in situations of unprecedented professional challenge after the

terrorist attack on the twin towers. Yet some participants thought that New York City "pulled off an amazing job" in providing mental health services to thousands of persons in distress following the attack, and many experienced a variety of clinical successes. Their reports describe interventions they found psychologically healing to their patients after this massive and violent attack.

In the attack's immediate aftermath, some participants saw value in unusual, and sometimes nonverbal, therapeutic interventions. In the view of one participant, the most effective relief workers were those

> "giving out the cookies and the coffee. They're the ones who are truly touching people. They create an environment where people will talk."

Two participants were struck by the "therapy dogs" stationed at various sites for the families of the deceased. Unlike their human counterparts, the dogs were available for physical contact and did not ask intrusive questions. As one participant noted, though people might not want to talk to a therapist, "you can pet a dog and you're relating."

Participants who worked with groups or in institutional settings found it helpful to teach people the physiology of traumatic stress reactions, to normalize their emotional responses to the attack, and to provide them with a supportive community. One participant who worked in a school felt he had successfully mobilized his "seriously traumatized" community's resources and skills, so that its members were able to "round up the wagons, pull together, and take care of ourselves."

A number of participants swore by their traditional clinical skills. Many who provided individual treatment found that after September 11, as in other therapeutic encounters, psychological healing occurred by virtue of

> "what happens between two people in a room, one who has some principles that they've learned. But essentially it's being there with another person and helping them to understand their experience and reframe their experience, hopefully, in some way that moves them forward."

Several participants found that September 11 required them to go beyond the traditional psychotherapist's role. In their view, psychological healing no longer depended on spending a specified amount of time alone with an individual they identified as a patient, in a particular kind of clinical setting, enacting a certain kind of professional reserve, expertise, and relationship. For them, psychological healing was no longer contingent on standard clinical theories, diagnostic categories, or therapeutic interventions, but on humane interactions. Recalling her work with rescue workers at Ground Zero after 9-11, one participant imagined a new role for psychotherapists that connected them with other healers who ministered to the suffering.

> "I wanted to use whatever spiritual capacities I have to connect in a real, authentic, humane way, in a present way, with other human beings, for even that five minutes, for even that one minute, for even that glance…Because it seemed to me that humanity is what mattered more than anything."

IMPLICATIONS OF THIS RESEARCH

After the terrorist attack on the World Trade Center, New York area psychotherapists frequently found themselves in uncharted terrain. Seeking to help persons injured by an act of mass violence, they worked under great pressure, in scenes of unspeakable destruction, chaos, and horror, where their standard clinical methods were often inappropriate. Confronting a kind of human tragedy for which their discipline had no category, inadequate knowledge, and for which it had insufficiently prepared them, they alternately faced outsize demands for help and found their presence unwanted. Transforming their usual professional models and roles to alleviate the suffering of others, their own suffering often went untreated, and grew worse after contacts with patients. Recognizing that those deeply hurt by the attack would not soon recover, and would need psychological treatment indefinitely, therapists resigned themselves to the fact that they would be reliving September 11 for years.

In light of such extensive challenges to their usual modes of practice, the sections below consider some of the implications of the attack on the World Trade Center for New York City mental health professionals.

Mental health preparedness

This research suggests that if psychotherapists are to be on the frontlines in the event of future terrorist attacks, and if mental health services are to be better coordinated, managed and implemented than they were after September 11, there are strong needs to improve mental health preparedness. Mental health preparedness would be best accomplished by establishing a clear conception of public mental health, as well as a permanent mental health infrastructure in New York City. Instead of assembling new mental health programs on an ad hoc basis following a catastrophe, or waiting for out of town experts to get into Manhattan, this infrastructure could be mobilized immediately after an attack. Such an infrastructure would supply appropriate mental health treatments, streamline the hundreds of mental health organizations providing relief, identify sites requiring relief, organize and deploy local mental health professionals, develop a system of continuous psychological care, create centralized databases of survivors and of the deceased, and supply therapists with up-to-date information on all relevant aspects of the catastrophe. It would also create services that are culturally informed, and that more effectively reach out to minorities, immigrants, undocumented workers, and other vulnerable groups.

Mental health preparedness also requires reconfiguring mental health training and research. If terrorism is viewed as inevitable, then mental health programs must equip psychotherapists to treat those who are injured by it. To assure that mental health professionals are properly trained, courses in the skills therapists found most useful after the attack, including crisis intervention, group treatment, disaster mental health, trauma, and bereavement, must become basic components of clinical education. Treatments developed for previous terrorist acts and disasters, both in this country and abroad, should be incorporated into curricula. There are

also clear needs for intensive research investigating the immediate and ongoing psychological consequences of terrorism.

In addition, mental health preparedness requires an adequate supply of psychotherapists. While thousands of New York area therapists generously donated their time after September 11, it is uncertain whether an equal number would volunteer in the event of another attack. A permanent mental health infrastructure must guarantee the availability of mental health professionals following large-scale catastrophes, and compensate them for their services. It must also ensure their psychological safety. This research suggests that mental health professionals are more vulnerable than previously believed, and that their immersion in the anguish of others may put them at psychological risk. This risk intensifies in situations of simultaneous trauma; it may also intensify if terrorist acts recur and retraumatize city inhabitants. Consequently, there are needs to develop protections and supports for psychotherapists who may be emotionally harmed by helping others injured in an attack.

Expanding the frame of psychotherapy

In addition to recommending improvements in mental health preparedness, this research suggests that treating the suffering caused by acts of mass violence may require expanding the frame of psychotherapy. As September 11 made clear, the field of mental health field does not offer adequate models for the treatment of trauma and bereavement. Nor does it offer adequate models for treating trauma and bereavement that exist in combination; or are deepened by multiple losses; or are worsened by physical injury; or are heightened by exposure to environmental toxins; or are complicated by unemployment; or are produced by incomprehensible terrorist acts; or are experienced in a climate of unrelenting anguish and threat. Moreover, the field of mental health does not offer adequate models for the treatment of trauma and bereavement that occur on a massive scale; that afflict communities as well as individuals, that

are contagious rather than contained, and that require alleviation at both the social and individual levels.

Such limitations may be addressed by expanding the mental health paradigm. This expanded paradigm might incorporate psychologies of terrorism and war, and create disaster-specific diagnostic categories and models of treatment. By partnering with other disciplines, it might be informed by new research on culture, society, memory, neurobiology, and epidemiology, so that it can develop new understandings of emotional contagion, of social bodies, of collective psychopathology, and of public mental health. Providing therapists with more effective conceptualizations of individual and community disorder may help diminish their risk of psychological harm.

The limits of psychotherapy

Alternatively, the findings of this research may suggest that mental health preparedness is impossible, that the mental health paradigm cannot be expanded, and that the events of September 11, by proving its theories and practices inadequate, expose the limits of this professional discourse. If human suffering cannot be verbalized, analyzed, or eased, if it cannot be assimilated to a person's life history, if it cannot be individualized or contained, if it cannot be made sense of in psychological terms, then frameworks other than those of psychotherapy may be required. In this view, if therapists have been injured by their clinical work since September 11, it is because they have been out of their depth; because they have been handling materials that are of a different scale than their tools, and that cannot be interpreted through their analytic frames. Further, if the psychological consequences of terrorism are contagious, then therapists who provide mental health services to terrorized populations may be systematically exposed to psychic injury. Therapists and patients may continually reinjure each other. Therapists who turn to colleagues for support may spread emotional suffering throughout their professional community, so that the strategies designed to reduce psychological harm may transmit it instead. Accordingly,

no type of clinical training can sufficiently prepare psychotherapists to treat persons who are devastated by a terrorist attack, nor can any amount of protection fully shield them from the emotional risks of their work.

Whether acts of terrorism can be treated by psychotherapists, whether the mental health paradigm can be expanded beyond its present limits, whether acts of mass violence call for perspectives beyond those psychotherapy offers, and whether psychotherapists might be shielded from psychological harm are questions that cannot be definitively answered here. These questions, however, require urgent consideration. If therapists are to be on the frontlines in future catastrophes and acts of mass violence, they must candidly address these professional challenges, and the limitations of their field.

CONCLUSION

More than a year after the terrorist attack on the World Trade Center, it remains impossible to fully comprehend either its impact on psychotherapists or its implications for the field of mental health. In the absence of such knowledge, many psychotherapists are less interested in specifying the nature and dimensions of human suffering than in participating in its alleviation. As they struggle to make sense of an event of mass horror, they have rededicated themselves to the relief of those who suffer, no matter what the cause. As one therapist who seemed for speak for the majority of those interviewed for this research stated,

> "There is great suffering. And the only meaning one can make out of suffering is in some way to be in opposition to it."

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