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Treatment Can Ease Lingering Trauma of Sept. 11

By ERICA GOODE

On Monday afternoons, Josefina Mendez now does something she has never done before: She goes to see a psychotherapist.

Normally buoyant and filled with energy, Ms. Mendez, who worked as a security guard at the World Trade Center, has been disabled by the horrors she experienced on Sept. 11.

She feels dizzy and has heart palpitations. Plagued by insomnia, she hardly sleeps; when she does, she has terrible nightmares. She is afraid of crowded places, startles at any loud noise and is reluctant to leave her apartment in Queens. Most upsetting, any reminder of the terrorist attacks sets off a cascade of terrifying mental images, like a movie she cannot turn off.

"Sometimes I feel like nothing happened, and then I remember again," she said. "The towers were swallowed, and it made me feel like I was going down, too, with the tower. It's not only that I lost my job, but I lost my friends, and I lost a piece of my life."

In mid-October, Ms. Mendez, 59, sought help at a medical clinic in Midtown Manhattan and was referred to Dr. Jaime Cárcamo, a psychologist in private practice who is also a researcher at Columbia University. Sitting in his office, she learned that she was not going crazy or having a heart attack, as she had feared. Instead, Dr. Cárcamo said, her symptoms were hallmarks of post-traumatic stress disorder, or P.T.S.D.

Dr. Cárcamo told Ms. Mendez that over time her anxiety would probably subside. He outlined a treatment called exposure therapy, which studies have found has been helpful to rape victims, combat veterans and other trauma survivors. Ms. Mendez would come each week for 10 sessions of 90 minutes, he said, and together they would tame the memories that torment her.

Experts have stressed that most people caught up in the events of Sept. 11 will get through the experience with the help of friends, relatives, clergy members and others in the community. But for up to 25 percent, they have estimated, symptoms severe enough to interfere with normal life may still persist months later.

Survivors of other traumatic events — Ms. Mendez narrowly escaped death in the 1993 bombing of the World Trade Center — are at particular risk for such difficulties, the experts say, as are people burdened by other stresses and those with existing psychiatric difficulties.

But locating effective treatment for traumatic stress symptoms can be difficult. Many therapists have no training in treating stress disorders. Others are offering untested therapies. Mental health organizations and government agencies are working to make reliable treatments widely available, but it is usually up to patients to decide what kind of help to pursue.

Fortunately, P.T.S.D. and other consequences of severe trauma are more treatable today than at any time in the past. That Dr. Cárcamo could reassure Ms. Mendez with some confidence, for example, reflects the large body of research on post-traumatic stress disorder that has accumulated since 1980, when the diagnosis first entered the psychiatric nomenclature.

Over the last two decades, investigators have developed scales to measure symptoms and to document patients' improvement. They have tested some treatments in clinical trials. And they have slowly begun to decipher the complex neurobiology that most experts suspect underlies the disorder.

Last year, for example, the International Society of Traumatic Stress Studies for the first time published a set of practice guidelines examining the effectiveness of a host of current treatments, from cognitive behavioral approaches, of which exposure therapy is one, to antidepressant drugs, group therapy and counseling.

"P.T.S.D. has gone from something that 25 years ago was obscure to being now one of the main psychiatric disorders studied around the world," said Dr. John Wilson, a professor of psychology at Cleveland State University and director of the Forensic Center for Traumatic Stress and P.T.S.D. in Cleveland.

Still, many questions remain about the treatment of the disorder, which is diagnosed when stress symptoms persist for one month after the event.

It is not yet clear, for example, whether people who have suffered different types of traumas might benefit from different types of treatment. Nor is it known whether a combination of techniques — therapy plus medication, say — might be superior to a single method, as has proved true in treating depression.

Disagreement also exists about the merits of different treatments. The methods most popular among therapists in clinical practice are not always those most supported by research. For example, though individual therapy and group therapy have proved their worth in the treatment of psychiatric ills like depression, they have yet to be studied extensively in trauma survivors.

In addition, practitioners trained in techniques backed by the most evidence, like cognitive behavioral approaches, may be hard to find.

"The fact that a particular treatment may not have research in favor of it is not the same as saying that particular treatment does or doesn't work," said Dr. Matthew J. Friedman, executive director of the National Center for Post-Traumatic Stress Disorders, part of the Department of Veterans Affairs.

Making matters more complicated, many survivors of traumatic experiences suffer not only from the narrowly defined symptoms of P.T.S.D. but from other, related difficulties like depression, alcohol or drug abuse or personality disorders. And if the traumatic experience involved the death of a close family member or friend, as was true for many people affected by the Sept. 11 attacks, untangling the grieving process from the traumatic circumstances of the loss becomes an important part of therapy.

Nevertheless, experienced therapists are able to negotiate a path through these complexities and help many people get better. And research offers a guide to treatments with the best chance of success.

Many effective treatments for P.T.S.D. address two elements that researchers believe lie at the disorder's core: first, traumatic memories that are so anxiety-provoking that survivors are unable to regulate their emotional responses, and end up avoiding people or places that set them off; and second, the cascade of normal physiological reactions to danger, which in traumatic reactions somehow become oversensitized and continue long after the threat is past.

Antidepressant medications, for example, lower anxiety and reduce sleep disturbances, startle reactions, intrusive memories and other symptoms. Two drugs, Paxil and Zoloft, have been found in large clinical trials to help many people with P.T.S.D., and experts say other antidepressants in the same family are also likely to work, though they have not been extensively tested.

Another proven treatment is exposure therapy, the kind Josefina Mendez is receiving, which rests on the notion that reliving traumatic experiences in a safe place helps people to gradually control their fear.

For example, patients may be asked to tell their stories over and over during the treatment. Or they

may write about their experiences.

"The idea is that by repeated confrontations with memories or situations that have a remote probability of causing harm, the person actually learns and modifies their expectations, and the anxiety goes down," said Dr. Edna B. Foa, a psychologist in the department of psychiatry at the University of Pennsylvania, who developed a widely tested exposure technique.

More than 30 randomized, controlled studies have found that exposure therapy and other cognitive behavioral therapies, most of which use exposure, are effective. "No other treatment model has evidence this strong indicating its efficacy," the international stress society said of exposure treatments in its practice guidelines.

Dr. Cárcamo, who is trained in Dr. Foa's technique, said that when Ms. Mendez first came to see him, he asked her about her symptoms, her history and what happened to her on Sept. 11. Was she injured? Did she fear she would die? Did she lose track of time, or feel she was observing things from a distance?

"The first session, she really wasn't able to talk about what happened to her," Dr. Cárcamo said. "She was very brief in what she talked about and there were a lot of things she didn't remember."

But on her second visit, Ms. Mendez was able to tell her story in great detail, how she had been standing on the plaza when the planes hit, how she ran through a dark cloud of dust and debris, how she sat on a fire hydrant on Varick Street, weeping as she watched the towers collapse.

At the end of that session, "she was actually very relieved," Dr. Cárcamo said.

In future sessions, he said, he will ask Ms. Mendez to recount her experience over and over in the present tense, periodically asking her to rate her anxiety level on a scale from 0 to 100. He will also teach her relaxation techniques to use when she becomes frightened, and give her assignments, like watching the news for one hour or telling a relative about her experience. At some point, he said, he may accompany her to a crowded place or in some other situation she fears.

Another form of treatment, eye movement desensitization and reprocessing, or E.M.D.R., shares some features with cognitive behavioral approaches like the one Dr. Cárcamo is applying. But while E.M.D.R. is popular with therapists and patients and has been found effective in treating some traumas, it has also stirred controversy.

Developed more than a decade ago by Dr. Francine Shapiro, a psychologist now at the Mental Research Institute in Palo Alto, Calif., the technique involves asking clients to summon to mind a traumatic image while the therapist moves a finger back and forth in front of the client's face. The client's eyes track the movements. Afterward, the client takes a deep breath, lets go of the memory and talks about the emotions, thoughts and physical sensations that came up during the procedure.

E.M.D.R. is taught in workshops around the country, and in some cases, practitioners say, treatment takes only a few sessions.

Dr. Shapiro and other E.M.D.R. proponents argue that the technique offers a nonverbal shortcut to the emotions and memories aroused by the traumatic event. "Maybe the brain can heal at the same rate as the rest of the body," Dr. Shapiro said.

Dr. Bessel A. Van DerKolk, a professor of psychiatry at Boston University, studies E.M.D.R. and believes it is helpful in many cases.

"It settles people down," he said. "You really see people go through some horrendous memories and then after a while they say, 'Yes, it happened,' and the memory's gone."

But other researchers and clinicians dismiss the claims made by E.M.D.R. practitioners as wildly exaggerated. They dispute the theories offered by Dr. Shapiro and others about how the therapy might work and call the eye movements "hocus - pocus."

"What is effective in E.M.D.R. is not new, and what is new is not effective," said Dr. Richard McNally, an associate professor of psychology at Harvard and a vocal critic of the technique.

In a recent analysis of 34 studies of E.M.D.R., Dr. Paul Davidson, a professor of psychology at Queen's University in Ontario, found that the therapy was effective for post-traumatic stress disorder in noncombat trauma. But Dr. Davidson also found in his analysis that E.M.D.R. worked just as well without the eye movements or other external stimulation as it did with them.

Even more controversial than E.M.D.R. is a widely used crisis - intervention method called debriefing, which in some versions involves a single group session in which survivors share their experiences. Advocates claim that if used in the immediate aftermath of a traumatic event, debriefing can help prevent post-traumatic stress disorder. But recent studies have cast doubt on this assertion. And some researchers have found that single-session debriefing can actually impede recovery, especially if emotional wounds are opened up but survivors are given no tools to cope with their distress.

Beyond the methods most thoroughly examined by researchers, a variety of other treatments may be helpful for trauma survivors and in some instances are more readily obtainable. For example, studies indicate supportive counseling works better for P.T.S.D. than no treatment at all.

And group therapy, a time-honored treatment in combat veterans, beginning with the "rap" groups for Vietnam veterans in the 1970's, is widely endorsed by therapists and patients, though carefully designed studies of group treatments are limited. Being in a group with other people who have had similar experiences, however, clearly helps trauma survivors feel less isolated, experts said.

Perhaps the most common treatment for traumatic stress is a variety of approaches in which individual patients simply talk with therapists. Talking therapy, including psychoanalysis, has been used since the early 1900's to treat combat veterans, Holocaust survivors and others whose lives have been disrupted by encounters with danger and death.

A large number of case reports by clinicians support the benefits of the therapy, though as yet few studies back up these anecdotal accounts.

"There are only a very few controlled trials," said Dr. Charles Marmar, a trauma expert who is vice chairman of the department of psychiatry at the University of California at San Francisco, "but there is a massive clinical consensus that time-limited, trauma-focused therapy may be helpful."

Given the wide array of treatments, researchers who study traumatic disorders agree that different people may benefit from different methods, and that some people may be more comfortable with some therapies than with others. Moreover, in some cases a single therapy might not be enough, and a combination of treatments — group and exposure therapy, for example, or medication and individual treatment — may be required.

In the end, most experts say, the goal is to find a therapy that helps calm both body and mind.

"The whole idea of overcoming trauma is to transform it into something else," said Dr. Van Der Kolk, "to calm yourself down and look at it from a distance."

