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The history of a virtual epidemic

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This chapter is an account of an episode in the War Against Terror. The War was a response to three attacks on September 11, 2001. Americans were told that 9/11 was the beginning of a war of terror The attacks also initiated a war against terror that included the Us invasion of Afghanistan, the passage of the Patriot Act by the Us Congress, and the creation of a cabinet-level Department of Homeland Security. Another consequence of the war against terror was an epidemic of a psychiatric illness and an incipient public health crisis. This chapter is about that epidemic.

This chapter is divided into three parts. Part one is a brief history of this epidemic. The 9/11 attacks were, in a sense, an instance of aerial warfare perpetrated against a civilian population. In part two, I consider an earlier instance, the Allied air war against German cities during World War II. There is a puzzling disparity in the numbers of psychological casualties following these episodes, 2001 and 1943-45. In part three, I offer a solution to the puzzle, at least for the American half of the equation.

Psychiatric consequences of 9/11

September 11, 2001: terrorists targeted are the towers of the World Trade Center (WTC), the Pentagon, and probably the White House. About 3,000 people died. Most of the deaths were at the WTC site, and it was the televised images of this attack that riveted worldwide attention. American political leaders and experts on terrorism described the attacks as acts of psychological warfare: the targets were chosen for their symbolic importance. Politicians and editorial writers compared 9/11 with the surprise Japanese attack on Pearl Harbor. The enemy was described as cruel but also cunning. Powerful images of the attacks were transmitted to the remotest corners of the country.

There is also a striking difference that would make 9/11 potentially more insidious and potentially more dangerous than Pearl Harbor. In the weeks and months following the WTC attacks, a threat hung «like the cloud of smoke over Ground Zero and parts of Manhattan, [This threat has] remained "in the air," never truly disappearing, never giving a concrete target for protective action. [...] Unlike the bloodiest air raids in war, there was no trusted safety signal ... and no safe places.... [and] boundaries between direct and indirect exposure were blurred... [The difference was only] a matter of *degree*» (SHALEV A. 2006: 607-608). From now on, every American might reasonably consider himself or herself a potential victim.

The most severely affected victims were the close relatives and comrades of people killed in the attacks. The Mayor of New York City and his administration expressed their concern for the victims' mental health. They were offered psychiatric care and counseling and an effort was made to protect victims from inquisitive outsiders. Trauma researchers were discouraged. A prominent biological researcher wrote that, because the attacks and their implications for the future affected the entire nation, 9/11 must be regarded as a collective trauma. The attacks have created a permanent public health emergency, comparable to an epidemic of infectious disease.

> «Terrorism is in essence ... an assault on the mental state of a population. ... It would seem obvious that public mental health should be a central element in any effective defense against terrorism. ... September 11 was the first major event since World War II which tied public health directly to national defence».

The ban must be lifted, it was argued, because information obtained from the most severely affected segment of WTC victims would yield the most valuable information on pathogenesis, treatment efficacy, etc. The ban was unfair to the victims because it denied them the opportunity to make a unique contribution to the national welfare. And it was a bad precedent.

Four years later, in an editorial in the New England Journal of Medicine, a researcher appealed to Washington to end the "moratorium on research". With the assent of Congress, the Bush administration had created a Department of Homeland Security. And now, the government's «preparedness to prevent and respond to terrorism ... should be extended to mental health research». The American public «needs to be alerted to the necessity of research and prepared for the operational procedures that would be implemented in the aftermath of terrorist attack». Government policy should encourage the development of «a culture of education in which the academic community can freely communicate what is and is not known, such that [future] survivors of terrorism will understand the value of their

participation in research to the generation of useful knowledge» (YEHUDA R. *et al*. 2005).

There had been no moratorium on research. It was mainly the established researchers who were habituated to working with the direct victims of traumatic violence who were closed out. There were other researchers however, many of them relative newcomers to the trauma field, who grasped the novelty of the WTC attack: it was an unprecedented combination of terrorism and television. The target of their research would be the victims of the "distant traumatic effects" of television. These victims would be counted in the millions and there would no obstacles – moral, political, or technological – separating them from researchers.

When American psychiatric researchers write about trauma today, their frame of reference is posttraumatic stress disorder (PTSD) as encoded in the current diagnostic manual, DSM-IV. TV images are not included in DSM-IV's list of "traumatic stressors" and the text does not mention "distant traumatic effects." However, DSM-IV introduced a significant change in the definition of the stressor criterion that opened a space for phenomena such as distant traumatic effects. The previous stressor definition specified direct exposure to an event outside the range of human experience and deeply distressful to nearly anyone. In DSM-IV, the traumatized victim is described as someone who «experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others [and whose] response involved intense fear, helplessness, or horror». Distant traumatic effects are presumed to represent a distinctive kind of traumatogenic "witnessing".

This term was first used in posttraumatic research conducted on a group of small children (TERR L. *et al*. 1999). Their teacher had prepared them for viewing the launch of the Challenger space shuttle, and a class project had acquainted them with the biographies of the shuttle's crew. On the occasion of the launch, the children watched together in the classroom a fatal disaster on television projected in real time.

I have located twenty-nine empirical studies of the "distant traumatic effects" of terrorist attacks in the United States. Sixteen studies are about the 9/11 attacks: three are based on national samples; seven are about regions beyond New York City (e.g., Arizona, California); and six concern parts of New York City beyond the WTC site. Findings were based on self-reports obtained from respondents or their parents, since some of the informants are grade school children. Structured interviews collected information on PTSD symptoms and television viewing: answers consisted of ticking off the

options. Questions relating to PTSD were based on standardized diagnostic instruments. Information was collected in various ways: telephone interviews were obtained by random digital dialing; questionnaires were given to undergraduate students and grade school children in class; an electronic diary technology required informants to record what they are thinking or feeling when prompted; a web-based technology developed by Knowledge Networks Inc., a marketing survey research company with on-going access to 60,000 American households, relayed interactive questionnaires via the internet. No studies included a qualitative research element. Some studies are based on single interviews. Other studies obtained responses at intervals, beginning a few weeks or months following the attacks. In some studies, informants, including young children, were asked to recall their emotions and viewing habits months, sometimes years, in the past.

Researchers report that, six months after the WTC attacks, seven million Americans living in regions far from New York City had "probable PTSD" connected to the WTC attacks (SILVER R. C. *et al*. 2002). In New York City, 360,000 people had probable PTSD as a consequence of televised images of the WTC attacks (GALEA S. - RESNICK H. 2005). On the first anniversary of the WTC attacks, many New Yorkers watched retrospective accounts that replayed the original images on television. Hundreds of thousands of New Yorkers, previously without WTC -related PTSD , developed "new-onset probable PTSD". African-Americans, Hispanic-Americans, and low income families were especially vulnerable to this effect (BERNSTEIN K. *et al*. 2007).

PTSD 's inner logic

Every psychiatric classification in the DSM diagnostic system is represented by a unique set of features. There is no expert consensus about the mechanisms that might connect diagnostic features in most classifications. PTSD is different. While most disorders are diagnosed with a "laundry list" of features, PTSD is defined by a distinctive process motored by the victim's traumatic memory.

PTSD is defined by four core features. *A traumatic stressor*: An individual is exposed, as either a target or an observer, to an event that threatens death, serious injury or mutilation. He responds with intense fear, helplessness or horror. *A traumatic memory*: A memory of the event is created and it recurs persistently. To be more precise, the traumatic experience is "re-experienced" in disturbing mental images, dreams, mimetic behavior, etc. *An adaptation to the traumatic memory:* The victim consciously or unconsciously

avoids stimuli that might trigger remembering, and numbs himself as protection from the emotional impact of remembering. Numbing behavior can include "self-dosing" with alcohol and drugs. *Autonomic arousal*: The manifest states are various but symptomatic of the survival response (fight-flight) and are stimulated by active memories or the unconscious anticipation of memories. They include irritability, difficulty concentrating, sleep problems, and hypervigilance.

Regarded individually, PTSD symptoms are non-specific and easy to confuse with depression and other disorders. Some symptoms, such as "difficulty concentrating", may be clinically unexceptional states. A symptom becomes a traumatic symptom when it occurs together with symptoms belonging to other phases: distress, adaptation, arousal. All phases must be represented to justify a PTSD diagnosis and only then can individual symptoms be called "traumatic".

Structurally, the logic is impeccable: all features are connected through cause and effect and the combination makes PTSD different from other disorders. *Empirically*, there is there is the problem false positives, since it is difficult, often impossible, to detect people whose clinical presentations mimic authentic (iconic) cases of traumatic memory.

Traumatic memory is associated with four kinds of mimicry: factitious, fictitious (malingering), attributed, and belated. To understand how these memories work, first consider the nature of episodic memory. Remembering is a reconstructive process. Bits of information distributed throughout the brain are activated, intersected and represented in as declarative content. Every act of remembering an event represents a "draft". The process and content that go into a draft are affected by a person's current mental state, emotional state, priorities and intentions; his "effort after meaning" (reflective processing), his interaction with interlocutors while remembering; and information acquired since the previous draft. Thus episodic memory is intrinsically malleable, open to revision.

Factitious and fictitious memories are efforts to reconstruct the past through memory work. Factitious memories are based on imagined or borrowed autobiographical events that the individual assimilates as representations of his own experiences. It is their origins ("source amnesia") rather than their spurious content that makes factitious memories different from fictitious memories (the product of a conscious process labeled "malingering").

Attributed memory is the mirror image of the iconic traumatic memory. The logic of iconic memory proceeds from a precipitating event to a memory and from this memory to a syndrome. Attributed memory runs

in the opposite direction. The case begins with a symptom or condition and proceeds to the selection of a real memory that now qualifies, *post hoc*, as the traumatic origin of the condition. Belated memory follows the same sequence, except that the individual infuses the memory with intense emotion (fear, horror, etc.) that the original experience did not possess.

When post 9/11 researchers report an epidemic of PTSD in America, they mean the real thing, the iconic case. In the following section, I will argue to the contrary, that these researchers have succeeded in producing something novel, sharing the dynamics of attributed memory.

Manufacturing an epidemic

A symptom becomes a traumatic symptom when it occurs together with symptoms belonging to other phases of the traumatic process. On the other hand, many "trauma" symptoms numerated in 9/11 epidemiological research have been collected in isolation – «My only symptom on this list is difficulty falling asleep» – or in combination with just one additional symptom. Clinically, an isolated symptom is meaningless. Epidemiological research provides an additional way of interpreting such symptoms: responses are collected and re-presented on the printed page, in the form of tables. In these tables, the four sets of symptoms appear and the process that defines PTSD emerges – albeit as the property of a collective body. What is now visible in the collective body – the traumatic process – can be taken-for-granted in the bodies of individuals. This is a familiar style of reasoning, called synecdoche, in which a phenomenon (a case of PTSD) is represented by one of its parts (one or two symptoms).

In 9/11 research, the cases are called "subthreshold PTSD", a development of a phenomenon first called "partial PTSD". Initial interest in partial PTSD focused on Vietnam War veterans and victims of sexual abuse. In the 1990s, Murray Stein and colleagues conducted the first epidemiological study of partial PTSD in the general population. Their findings suggested that partial PTSD is as prevalent as full PTSD and carries a similar burden of disability. Thus «clinicians will be well advised to broaden their diagnostic scope and to consider intervening when traumatized patients fall short of meeting the full criteria set for PTSD . In addition, if partial PTSD is proven ... as prevalent and disabling as our data suggest, then public health policy makers will need to tackle a considerably larger problem than had previously been imagined» (STEIN M.B. *et al.* 1997: 1118).

A few experts have criticized these innovations – distant traumatic effects, subthreshold PTSD, etc. – and the researchers' conclusion that the 9/11 attacks triggered an epidemic of PTSD. They argue that the DSM-IV stressor criterion has sanctioned «conceptual bracket creep», undermining psychiatric science. Anyone who watched television coverage of the carnage of 9/11 can qualify as a "trauma survivor." Respondents' emotional responses are irrelevant if they do not also entail a functional impairment. If there was no impairment post 9/11, there was no increase in disease, and therefore there was no there was epidemic (BRESLAU N. - MCNALLY R. 2006: 522). The traumatologists' consummate hubris is to suggest that the absence of pathological reactions (PTSD) following 9/11 is not normality:

> «The failure of epidemiologists to detect a marked upsurge in trauma-induced mental disease following 9/11 was interpreted by trauma researchers and commentators as evidence of resilience. The non-epidemic of PTSD has not prompted a critique traumatology's basic assumption: the expectation of breakdown. Rather, the non-epidemic has been interpreted as confirming that assumption by invoking a complementary aspect of trauma and victimization, that of resilience, an unexpected capacity to go on with life with minimal psychological damage» (BRESLAU N. - MCNALLY R. 2006: 525).

The response of the trauma experts has been swift and terrible. In an editorial afterward to 9/11*: Mental Health in the Wake of Terrorist Attacks*, a lauded compendium of post 9/11 research, Randall Marshall writes: «Where does one begin to respond to Breslau and McNally's assertion that there "was no mental health epidemic after 9/11"?». Breslau and McNally ignore scientific findings and are like people who believe that the NASA moonwalk was a hoax filmed on earth. Their failure is likewise moral:

> «It is unfortunate, but this chapter abandons the basic principle that mental health scientists should concern themselves with recognizing and responding to public health needs. The ethical consequences of minimization or outright denial of human suffering after large scale traumatic events are profound. [It] was perhaps inevitable that an event with profound political consequences from the start would become politicized» (MARSHALL R. 2006: 626-627).

Most scientists might argue that "the basic principle" when assessing scientific research is epistemological. Marshall is implying that "trauma symptoms" and "large scale traumatic events" are special in this regard. I believe that this may be a common attitude, probably shared by a majority of ordinary Americans. If it is, then it must be considered when one interprets 9/11 data based on responses to questionnaires. Twenty years ago, posttraumatic stress was largely the preserve of psychiatry. Today the language of trauma permeates everyday discourse, television and radio talk shows, print journalism, popular fiction, etc. The language of posttrau-

matic stress is becoming the Esperanto of global suffering and the first non-denominational medium through which well-meaning people can *and should* express their compassion and publicly affirm their shared humanity with all classes and cultures.

The 9/11 researchers asked respondents for information that might explain their self-reported symptoms: their television viewing during and following 9/11, demographic characteristics, etc. But no informants were asked about their prior knowledge of PTSD. It seems likely that adult respondents with some basic understanding of PTSD would be inclined to situate the interviews in this context – especially when, in major studies, they were asked explicitly if their symptoms could be related to the WTC attacks (e.g. GALEA S. *et al*. 2002).

Today, PTSD is not only a psychiatric classification, It is also a cultural template that shapes Americans' expectations about how normal people do, and therefore *ought to*, respond to events like the 9/11 attacks. Did this ordinary knowledge affect respondents' answers and, in this way, contribute to establishing the association between TV viewing and trauma symptoms? Donald Rumsfeld, a former Secretary of Defense, has made a useful distinction between "things that we don't know" and "things that we don't know that we don't know". The cultural meaning of PTSD and trauma is something that the 9/11 researchers don't know that they don't know.

The air war against German cities

The inevitability of PTSD in these circumstances seems unarguable so long as one ignores the historical record of terror bombing. A million tons of bombs dropped on German cities during World War II. Perhaps 500,000 civilians died. Millions survived and remembered hours of intense fear and helplessness and the gruesome deaths of relatives and neighbors (FRIEDRICH J. 2006, NOSSACK H. E. 2005). In lectures given in 1995 in Zurich, the novelist, W. G. Sebald, spoke about these memories. Sebald was born in 1944 in a rural region and had no personal memories of the war. His talk was about the remarkable absence of social memories – recollections made public – of the air war. Social life had revived rapidly after the war. «People's ability to forget what they do not want to know, to overlook what is before their eyes, was seldom put to the test better than in Germany at that time. The population decided – out of sheer panic at first – to carry on as if nothing had happened» (SEBALD W. G. 2003).

The absence of psychiatric statistics and reports on the effects of the air war give the impression that nothing had happened. From 1941 to 1945, the Security Service (SD) monitored civilians' responses to bombing raids. The SD's "mood reports" indicate that morale remained unbroken. After 1943, reports mention grumbling about overcrowded shelters and instances of "shelter fever" resulting from confinement underground, but psychological and psychiatric problems are not mentioned. Civilians were expected to see themselves as members of "community of fate" (*Schicksalgemeinschaft*) that they shared with German soldiers, who, by 1943, were suffering enormous casualties and misery on the Eastern Front (GREGOR N. 2000).

Sebald believed that the mental suffering of the survivors continued to be ignored after the war. Heinrich Böll had explored the subject in his «melancholy novel of the ruins *Der Engel schwieg* [but it] was withheld from the reading public for over forty years....». According to Sebald, although other writers had taken up this theme, their books were either inept or mere experiments in which «the real horrors of the time disappear through the artifice of abstraction and metaphysical fraudulence» (SEBALD W. G. 2003: 50). The conspicuous exception was Gert Ledig's *Vergeltung* (*Payback*), published in 1956. But the reviews were negative: the book is "a deliberately macabre horror painting" and barely credible (TORRIE J. 2003). Sales were poor, and *Vergeltung* drifted into oblivion. By 1997, the situation seems to have changed. Sebald's Zurich lectures, published in Germany that year, attracted much public attention and also respect:

> «...I thought my claim ... would be refuted by instances which had escaped my notice. Not so; instead everything I was told in dozens of letters confirmed me in my belief that if those born after the war were to rely solely on the testimony of [post war] writers, they would scarcely be able to form any idea of the extent, nature, and consequences of the catastrophe inflicted on Germany by the air raids» (SEBALD W. G. 2003: 69-70).

There appears to have been a corresponding absence of psychiatric concern with civilian survivors during the war and in the immediate postwar period (MAERCKER A. 2002, MAERKER A. - HERRLE J. 2003). I have been able to locate only one report. In 1947, Kurt Beringer, a former colleague of Karl Jaspers at the University of Heidelberg, published an account of his clinical experiences treating survivors in Freiburg, a city subjected to repeated devastating air raids. Beringer's account also includes information he collected from psychiatrists treating survivors elsewhere in Germany (BERENGER K. 1947). «People waited in subterranean shelters, powerless and passive, [knowing] that in the next second their lives might end, swiftly or painfully». However "abnormal reactions" were rarely observed; Beringer mentions no long-term psychological consequences.

Post 9/11 researchers report that repeated exposure to the 9/11 images increased the probability of developing Maercker. Risk tripled in people who were exposed to two prior events; three events meant a six-fold increase (GALEA S. *et al*. 2006: 33). Most German survivors of the Allied bombings were exposed to multiple air raids. Each experience met the DSM criterion for a "traumatic stressor." The analogous population in post 9/11 America would be people said to be "directly affected" by the attacks: individuals who «reported that they were in the WTC complex during the attacks, were injured during the attacks, had a friend or relative killed, had possessions lost or damaged, lost a job as a result of the attacks, or were involved in the rescue effort». Researchers estimate that 3.7 million New Yorkers meet this description and the prevalence of PTSD in this group six months after the attacks was 12%. This means 420,000 psychiatric casualties (GALEA S. - RESNICK H. 2005).

The number of German civilians exposed to Allied bombing exceeds the number of people living in New York at the time of the 9/11 attacks. The "directly affected population" in Germany would, on the average, have experienced more intense stressors than the comparison group in the US and they would have been subjected to multiple exposures that would, in turn, exacerbate the traumatic effects. Thus we might reasonably expect to find hundreds of thousands of casualties with diagnosable posttraumatic syndromes during the war and into the postwar period.

According to Beringer's account, there was no epidemic of psychiatric casualties in Germany. How do we explain his report? There are these three possibilities. There were huge numbers of psychiatric casualties in Germany, but they were not detected by medical authorities. There were huge numbers of psychiatric casualties, medical authorities were aware of them, but they and other Germans were unwilling to acknowledge them. The third possibility is that Beringer's impressions are consistent with reality.

We can reject the first possibility. It is unlikely that massive numbers of cases would have slipped by entirely unnoticed. German doctors were familiar with posttraumatic disorders and many psychiatrists, including Beringer, had treated many cases of traumatic neurosis during WWI. It is true that German psychiatrists were in very short supply during this period, and resources and motives required for studying reactive disorders in the general population were lacking. But these deficiencies are insufficient to explain the epidemiological disparity between post-war Germany and post 9/11 America.

The second possibility is consistent with Sebald's thesis that Germans had suppressed collective memories of collective suffering caused by Allied bombing. The death and destruction caused to civilian populations in Dresden, Hamburg, Berlin, and other German cities were not collateral damage. This was the goal of the Allied bombing campaign from 1943 to 1945. The Nazi Propaganda Ministry called it a "terror campaign" and said it was the result of Jewish influence on British military planners (MOELLER R. G. 2006). It seems that many ordinary Germans shared this belief in their victimhood (e.g. INGRAM M. 2006). After the war, Germans had strong motives for keeping their victimhood secret. German silence was an adaptation to German "Holocaust shame". The Jews were victims, the Germans were perpetrators; how can perpetrators claim to be victims? This is the suppression thesis.

Gerhard Giesen has recently proposed a repression thesis, according to which postwar Germany responded to the disclosure of the Holocaust with an "inability to mourn":

> «There was no way of telling a story about how it could have happened. Nobody can bear to look at the victims. [The] collaborators in a mass murder could not repair their ruined moral identity even if they had been ready to confess their guilt ... life is spoilt. The trauma is insurmountable. As a moral subject the person is dead. He or she can only remain mute... A tacitly assumed coalition of silence provided the first national identity after the war» (GIESEN G. 2004: 116).

The victims of the air war unconsciously colluded in German silence about German victims. Their silence was the result of two traumatic events: the air raids and their discovery the Holocaust. According to Giesen, a traumatic memory recalls a moment when «consciousness was not able to perceive or to grasp [an event's] full importance...». After a period of latency, it is called into consciousness and can be put into words. At this point the memory expresses itself as an identifiable syndrome – «delayed onset PTSD» (GIESEN G. 2004: 113). If Giesen's account is correct, we can conclude that Beringer mistook the period of latency for an absence of psychopathology.

The situation of bombing victims changed in the 1980s, at the time of the "historians' dispute" (*Histrorikerstreit*). This was no mere academic skirmish. It was widely reported in German newspapers and attracted popular attention. Ernst Nolte had argued that the Final Solution was not uniquely evil and that it could be compared with the mass murders and deportations perpetrated by the Stalinist regime. The historical roots of the Nazi and Stalinist programs were European, not specifically German. The template had been the reign of terror during the French Revolution (MOELLER R. G.

2003: 166-8, 175). Jörg Friedrich has now advanced a similar idea – the commensurability of victims thesis – in his widely read history of the Allied bombing campaign, *Der Brand*. Its subtext is that German responsibility for the Holocaust is undeniable but must not prevent Germans from talking about the crimes committed against them (MOELLER R. G. 2006: 115).

But was there really a coalition of silence in the postwar period? Public demonstrations in East Germany in the 1950s condemned the ruthlessness of capitalist America. The message was that the United States had perpetrated a criminal air war against German civilians and it was repeating this performance against the people of North Korea. And the consequences of the air war were also publicly and routinely acknowledged in West Germany:

> «[The] legacy of falling bombs became part of local histories and school atlases which carefully documented the extent of destruction, monuments memorialized those whom the bombs had killed, and at annual days of mourning political leaders recalled the dead. The rubble left by Allied bombers defined an entire genre of movies – the so-called 'rubble films' made in the immediate post-war period» (MOELLER R. G. 2005: 114).

In reality, there had been no taboo on talking or writing about the suffering caused by Allied bombing in postwar Germany. And there had been no explosion of delayed onset PTSD. The taboo subjects had been German victimhood and Allied culpability: it was the moral and not the medical interpretation of events that mattered. Further, the lack of attention given to the bombing victims can be usefully compared with the successes of another group of victims: the German civilians who had fled or were expelled from Prussia (now Poland) and countries with large pre-war German populations, notably Czechoslovakia and Rumania. These people lost their homes and property, experienced severe privation, and suffered many violent deaths. So their experiences approximated the bombing victims' suffering. But the *heimatlos* people coalesced into a self-conscious and politically influential «community of memory» (MOELLER R. G. 2005) divided into regional associations, while the bombing victims remained an atomized and amorphous population, waiting for a novelist or historian to give them a social identity.

Understanding disparity

In brief, it seems that there is a huge disparity in psychiatric casualties following the 9/11 attacks and the Allied air war against German cities.

One possibility is that the German casualties were undetected. The second possibility is that information regarding the casualties was suppressed during the postwar period because of Germany's Holocaust shame and its desire to maintain good relations with its Cold War patrons, the United States and Great Britain. In either case, the conclusion is the same: there is no disparity. But the available evidence supports neither position. The remaining possibility is that Beringer was correct when he wrote that there was no epidemic of chronic posttraumatic disorders in postwar Germany among survivors of the Allied bombing.

There is a true but puzzling disparity between the two situations: collective trauma in postwar Germany and post 9/11 America. The puzzle cannot be resolved by counting traumatic outcomes (cases) and comparing the totals. There is a missing piece, an antecedent question, a matter concerning cultural epistemology rather than epidemiological methodology. This question is: *What counts as an "outcome"?* For example, what kind of behavior will count as a "symptom" or a "posttraumatic reaction"? The questions are relevant to both situations: Why were there few posttraumatic cases despite exposure to terrible events? Why were so many posttraumatic cases recorded following exposure to televised events?

Conclusion

Richard McNally believes that the post 9/11 epidemiologists have contributed to «conceptual bracket creep» (McNally R. 2003: 232). They «medicalize expectable human reactions by failing to discriminate between genuine symptoms of disorder and normal distress reaction». McNally wants a more rigorous stressor criterion, similar to the original definition in Dsm-III and Dsm-IIIR. It won't happen. The posttraumatic syndromes are intrinsically historical phenomena: they are historical in a way that is different from other psychiatric disorders. The syndromes have been continually redesigned to meet transient social and psychological needs since the late nineteenth century. The major transformations have come during or following certain times of great historical violence: World War I, the Holocaust, and the Vietnam War. The War on Terror provides the raw material for another chapter in this history. The mass production of Ptsd of the virtual kind is something new but it is not an aberration. It is a metamorphosis.

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