IN THE FACE OF TERRORISM: THE RESPONSE AND RESPONSIBILITY OF PSYCHIATRY

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Political organizations such as the United Nations have had great difficulty in defining terrorism. The issue has been obscured by phrases such as: "One man's terrorist is another man's freedom fighter." Interestingly, the victims of terrorism have no difficulty in recognizing its occurrence and in making the appropriate distinctions. As scientists we must attempt to avoid some of the pitfalls of politics and perform the frequent task of psychiatrists, which is to assert reality. The targeting of civilian life and property as a means of achieving political goals in the absence of a formal declaration of war is an adequate definition. Under the conditions of a formal state of war civilian populations may suffer significantly but this is consistent with the concept of total war. Civilians contribute to the war effort in real ways and are therefore targeted. The school children at Beslan and their families, for example, did not represent such a target. Terrorism is a tactical weapon and must be understood as such.

The goal of terrorism is to break the will of the population to resist through the induction of fear. Strong negative affects such as fear induce a fight-or-flight response. It is also possible that the individual may lash out inappropriately. Both of these outcomes are psychologically undesirable. Withdrawal in the civilian population leads to ineffectiveness. Measured anger can lead to appropriate responses, but uncontrolled rage is very unlikely to be productive. The automatic fight-or-flight response must be modulated.

Intense fear can, in susceptible individuals, induce a state of severe stress called Post Traumatic Stress Disorder (PTSD). While initially observed in combat troops, it can occur in civilian populations as well. According to the *DSM-IV* (*Diagnostic and Statistical Manual of Mental Disorders*) and the *ICD-10* (*International Statistical Classification of Diseases and Related Health Problems,* 10th Revision), post traumatic stress disorder occurs as a result of exposure to a traumatic event in which the subject has experienced or witnessed events that threatened death or serious injury. Furthermore, the individual's response involves a sense of fear and helplessness. Both the experience and the emotional response to the experience are necessary for the onset of PTSD.

Suffice it to say, that our treatments are less than excellent and prevention may well be the order of the day. The level of anxiety, about the possible occurrence of terrorist activities, if sufficiently high could induce PTSD in the civilian population. After Beslan and 9/11 it was found that people developed PTSD from watching television reports of the actual incidents.

Psychiatry has much to contribute to our understanding and response to this threat. It is well-known that violence of human design has a greater impact on mental health than comparable natural or technological disasters. Perhaps of equal importance is that violence associated with terrorism is not transient but rather is both sustained and unpredictable. As would be expected the most common psychiatric sequelae are post-traumatic stress disorder and depressive states. What is of great significance is that many people who are not directly exposed to the actual event experience psychiatric sequelae.

The responsibilities of psychiatry can be divided into those which are orientated towards the government and those which are orientated towards the population. Psychiatry can consult with the appropriate governmental agencies in terms of issues surrounding psychological warfare and its appropriate countermeasures. We need to understand how to break the will of the terrorists just as they attempt to break the will of the targeted population.

At the population level one can divide the approach into three layers. Stated most simply it would involve actions before, during, and after the event. Before the event one must work towards improving the resiliency of the population through educational and other means. In this manner the anticipatory anxiety will be reduced so that it will not have the same degree of shock effect when the event in fact does occur. One must also strive to improve the coping mechanisms available to individuals when they are dealing with the actual event. Identifying ways in which the individual does not loose his or her sense of autonomy are critical. Those who respond to the event by helping others do better than those who become paralyzed by fear. Finally, we must treat those who have been injured by the event. Much research needs to be done to understand whether post-traumatic stress disorder and post-terrorist event depression are sufficiently homogenous to allow for single strategic interventions. We must also be able to create a public health response involving the use of paraprofessionals so as not to overwhelm the limited resources of the professional community.