Psychological Aspects of Terrorism

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Plenary 1: Lessons from History

500 Years of the Royal College of Surgeons of Edinburgh

John Orr
Vice President, RCSEd

500 Years of Resuscitation

Dr. Ronald Stewart

500 Years of Emergency and Disaster Medicine

Jonathan Marrow
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In 1500, London was a crowded, bustling, and bad-smelling home to about 100,000 people. Most lived on the premises where they worked or at least within walking distance. Most knew little of the world beyond their parish, let alone cities such as Moscow, Constantinople, or the Indies. Vasco da Gama took 10 months to travel from Lisbon to Calcutta in 1498. In 1588, a chain of beacon fires passed news of the arrival of the Spanish fleet to Channel from Plymouth to York (about 550 km) in 12 hours, but for more complex communication, the quickest method was a relay of horses, or a fast boat and a fair wind. Even in 1860, the Pony Express communication system in the United States took almost eight days to carry news of the inauguration of Abraham Lincoln from St. Joseph, Missouri, to Sacramento, California (about 3,000 km).

About 7,000,000 people live in Greater London today. One can fly from Heathrow airport to Calcutta in 10 hours, and worldwide communication by voice, image, or written word takes only seconds.

Earthquakes and floods always have been with us, but we know more about them and their effects than our forefathers did 500 years ago. Our skills in communication and control of energy have enabled us to organize aid for victims much more efficiently, but also have brought new kinds of injury and catastrophe.

Drawing from literary, historical, and medical sources, the changing pattern of injury and disaster alongside technological advances and improvements in the care of the individual injured patient will be illustrated.

Keywords: communication; disaster; history; London; technology
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Theme 1: Psychosocial Aspects of Disaster

Chairs: Gloria Leon; David Alexander

Overview of Psychosocial Issues of Particular Importance in Planning for Disasters and Terrorism

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The presentation covers the salient points raised and general discussion that took place at the Melbourne World Conference on Disaster and Emergency Medicine (WCDEM) 2003 Psychosocial Task Force meeting. A primary issue commented on is the importance of adopting a cultural perspective in planning for and managing disasters and terrorism, including attention to norms and practices of different ethnic groups. The adaptation of guidelines for local use that could utilize the strengths of the particular community was highlighted as well. The specific and sometimes differential needs of rescue workers, the elderly, and children were also considered. Members commented that psychosocial planning must be carried out in a way that does not undermine the psychological strengths and capabilities of the individuals affected by disasters, nor override the plans and facilities already present in the community. In essence, a primary goal of early psychosocial intervention should be to "do no harm." Gender differences in reactions were discussed, particularly observations in war/refugee environments that men tended to respond by feeling that they had failed to protect their families from harm, while women's overriding concern was the safety of their children. In addition, it was felt that there has been little attention given to the problem of how to deal with the use of rape and fear as an instrument of war and terror. Another topic explored was the connection of disaster managers with the media, and the optimal way in which relevant information can be provided to the community regarding the particular threat. The integration of research and practice to learn from previous events and plan for more effective future responses was viewed as a critical need. The task force concurred that an overriding goal must be the incorporation of psychosocial activities into disaster planning and response, that is, adopting a holistic orientation that includes dealing with psychosocial aspects, in all of its ramifications.

Keywords: disaster; media; psychosocial; response; terrorism
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Cultural Context of Psychological Defense Mechanisms Following Mass Disaster and War Trauma Experiences of the Earthquake in Armenia and War in Karabagh

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This paper reports on our experience in providing crises intervention for two types of traumatic events: (1) natural (the earthquake in Armenia); and (2) human-made (war in Nagorno Karabagh). The aim of this presentation is to show the influence of trauma on the psychological development of children and adolescents, with a special focus on the role and influence of culture on the defense strategies. The ability of children and adolescents to cope with a traumatic situation is determined by their defense mechanisms and coping strengths. This research is based on assessment and subsequent treatment of 270 traumatized individuals, including 116 children and adolescents from the earthquake-affected regions, and 79 children and adolescents

and 75 adults from the war region. Researchers administered the Childhood Post-traumatic Reaction Index, anxiety questionnaires, projective methods, and clinical case examples. Observed reactions in the three groups of subjects (pre-school, school-age, adolescents) are as follows: (1) phobic reactions; (2) psychosomatic disturbances; and (3) affective disorders. The most frequently observed defense mechanisms found were denial, regression, splitting, altruism, and sublimation. Examples of each will be presented with clinical material.

A key issue in the psychological response to disaster is the effect of bereavement and loss. Individual reactions are determined by one's developmental stage, temperament, past experience with trauma, and resiliency. The powerful link between response to trauma and social cultural factors are elaborated.

1. The JFDP is an academic exchange program administered by the American Councils for International Education (ACTR/ACCELS), and is fully funded by the Bureau of Educational and Cultural Affairs of the United States Department of State.

Keywords: children; coping; defense mechanism; disasters; psychological response; traumatic events
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Culture-Sensitive Aspects of Psychosocial Post-Disaster Care in the Netherlands after the Bijlmermeer Airplane Crash and the Enschede Fireworks Disaster

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Introduction: When a disaster strikes, a large group of people may be affected either mentally or physically. This group, although united by their communal ordeal, may consist of people of different ethnic or cultural origin. Ethnic or cultural minorities generally are considered to be at-risk groups when it comes to the effects of a disaster. In 2003, Impact, the Dutch knowledge center for post-disaster psychosocial care, started a project called "Lessons Learned". This project reviews the psychosocial interventions in the Netherlands regarding the affected ethnic minority groups of the Bijlmermeer airplane crash (1992) and the Enschede fireworks disaster (2000) in order to make recommendations for psychosocial interventions if disasters occur again.
Methods: Obstacles are identified and recommendations are formulated after analyzing >55 evaluation reports, scientific studies on psychosocial interventions after the two disasters, descriptions of treatments, and by interviewing various caretakers who were involved with the preventive, curative, and care interventions.
Results: Language problems emerged quickly, causing communication gaps during the aftermath of the disasters. To improve communication, a number of measures were taken from the start, and others were added after some time. Cultural differences and codes interfered with reaching the various ethnic groups, and with the success or failure of the available treatments. Some other factors were important as well. A multidisciplinary approach, cooperation between (mental) health institutions and community centers, and the sharing of knowledge and information all were essential in mitigating the psychosocial consequences of a disaster for everyone concerned. A continuous update of skills and knowledge for (mental) health personnel regarding a multicultural population remains an issue that should not be overlooked.
Conclusion: The Dutch experience with two major disasters makes it clear that a uniform psychosocial approach may not be sufficient to provide psychosocial care to all affected people. When it comes to preventive actions, interventions during the acute phase and psychosocial aftercare on the medium- and long-term and a more fine-tuned approach geared to the special needs and conditions of various sub-groups is essential to help alleviate the pain and stress caused by a disaster.

Keywords: care; communication; cooperation; cultures; language; Netherlands; post-disaster; psychosocial
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Humor and Religion: How an Emergency Department Coped with the 2003 Severe Acute Respiratory Syndrome (SARS) Outbreak

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Objective: This study examined the psychological coping strategies adopted by emergency department (ED) healthcare workers who cared for Severe Acute Respiratory Syndrome (SARS) patients during the outbreak in Southeast Asia in the spring of 2003.
Methods: During the outbreak from 13 March to 31 May 2003, the ED in the study was Singapore's only SARS-screening center and was closed to all other patients. The use of personal protective equipment and directives for infection control were strictly enforced. Heathcare workers experienced unusual stressors, namely, the unknown nature of the disease; the fear of infection, contagion, and death; stigmatization and discrimination; disruption of normal work and lifestyle; and conflicts with the sense of duty to care for patients and sick colleagues. To help healthcare workers cope, the study hospital and ED introduced psychosocial measures including: (1) enhanced communication within the hospital and ED; (2) enhanced communication with the community and public relations management; and (3) welfare and psychological support for healthcare workers.

In November 2003, a self-administered survey of ED doctors and nurses was conducted. Data collected included demographics and responses to Coping Orientation to Problems Experienced (COPE), which groups coping responses, according to 15 scales, each with a minimum score of 4 and maximum of 16. The higher score in a scale meant more use of that coping response. The scales were then categorized into problem-focused and emotion-focused strategies, which were adaptive, or less-useful/adaptive strategies.
Results: Thirty-eight (92.7%) of 41 doctors and 58 (69.9%) of 83 nurses responded. The mean age of the doctors was 31.6 years old (standard deviation (SD) = 4.4) and the mean age of the nurses was 32.1 years (SD = 9.2). Respondents scored 9.9/16 (95% Confidence Interval (CI) = 9.5–10.3)