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EDITORIAL

Don't panic! Short and long term psychological reactions to the new terrorism: The role of information and the authorities

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The possibility of a chemical, biological or radiological (CBRN) terrorist incident has been highlighted in a number of recent press reports. The role of information made available to the populace has also been recently debated especially in the context of travel warnings. In this editorial I will argue that the role of information is important to consider as it may have effects not just on decisions about travel arrangements but also on psychological and social responses to a CBRN attack. The role of our leaders is the key to reducing damage and this depends not just on their reactions now but on a systematic programme of research into possible consequences of CBRN – not a piecemeal response following an attack.

Panic and why people usually don't

There is a general and repeated perception that when facing severe and overwhelming adversity, people will panic. But what has happened in the past? Take the example of the London Blitz during the Second World War. Beforehand every expert, psychiatrist, planner and government official was firmly convinced that the ''bomber will always get through'', and that civilian morale would rapidly crack, with populations fleeing to the country in panic. Yet it didn't happen, except in a few very specific circumstances, such as the Bethnal Green Tube tragedy, when a crowd surged into a crowded subway entrance. The myth of ''London can take it'' is no myth. London did take it (Jones *et al.*, 2004).

Likewise, it seems clear from the research on 9/11 that panic was conspicuous by its absence during the evacuation of the World Trade Center. A building was on fire, about to collapse and the emergency services not yet present. Yet there was no panic, but an orderly evacuation perhaps aided by pre-existing social networks (Glass & Schoch-Spana, 2002). Why not?

There are many reasons. First of all, people can and do become habituated to great hardship. Initial responses can decrease over time as the threat continues, and assist people

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in gradually habituating to the new anxiety. This process can happen with some rapidity, as seen in the responses to the SCUD missile attacks in Israel in 1991 (Solomon, 1995). The population of Israel, whilst clearly experiencing significant psychological distress as a result of the current suicide bombing campaign, nevertheless continues to go about its business (Sheppard, 2005).

Second, during the period of the London Blitz civic leadership was strong, and examples of leadership common. Likewise, in modern times there was the example of the civic leadership role of Mayor Giuliani after 9/11 and his unequivocal assumption of the basic resilience of those affected.

But there are also instances in which this leadership has not been forthcoming. The initial reactions of the US leadership to 9/11 and anthrax had Vice President Cheney being reported as moving to yet another undisclosed location. People were entitled to say ''well, if they can't protect him, what chance have I got? And why should I stay put if he doesn't?''. In comparison the risk messages in the UK, which, by design, appealed to national stereotypes of resilience (the Blitz, the IRA campaign in London), in which civic society had coped, made it clear that panic was a concession to our enemies, whilst avoiding Corporal Jones' famous injunction ''don't panic!''.

One difference between the past and present is the collective purpose – by 1944 perhaps 80% of the UK adult population were involved in some form or other in the war effort, either in the Armed Forces or the voluntary sector. Whereas in the so called ''war on terror'', there is no clear role for civilians, other than to submit to ever more ingenious ways of being humiliated and harassed at modern airports.

Finally, risk in the London blitz was arbitrary. The leadership were almost as much at risk from the bombing as those rather lower down the social order – or at least it seemed that way. On the other hand, during the 2001 anthrax crisis in Washington there was a perception that officials reacted more vigorously to the threat to Congress than to the postal workers, who were more likely to come from disadvantaged ethnic minorities. The consequences of that misjudgement are still being felt. Historians have also suggested that one of the many reasons why the Vietnam war seemed to lead to far greater long term psychiatric illness in those who served there, in contrast to the Second World War in which casualties and the chance of combat exposure were much higher, was because the military itself was no longer viewed as representative of the citizenry as it had been. One historian said that ''Vietnam was the war our servants fought'' (Shephard, 2000).

In summary, people are more resilient than we give them credit for, and our leaders can trust their populations more than they sometimes seem to do.

The uses and abuses of reassurance

People are more resilient than you think and of course people are anxious about the threat from CBRN terrorism for many reasons. So if people are anxious, we should reassure them. Or should we?

The audience for this paper will be very familiar with basic psychology and learning theory, but it is worth repeating for a wider readership. Imagine a patient who has a phobia about going on the subway. Every time it is mentioned he develops panic attacks. And how is this person treated? Do we agree with him that the subway is a dangerous place? Make sure you don't go near the tube? Obviously not. Do we reassure? Discuss the tube safety statistics? No. Do we go over the tube evacuation plans? No.

Why not? Because reassuring anxious patients does not reduce anxiety, because the true cause of the anxiety has not been addressed. Seminal work from Paul Salkovskis and Hilary

Warwick established that far from reducing anxiety, the act of reassuring fears that are out of proportion to the threat involved, merely increases them (Warwick & Salkovskis, 1985) – this became the basis for the successful psychological treatment of hypochondriasis. Instead the treatment of choice is exposure – exposing the person to their fears, by making them travel on the tube, and confront their fears. And it is very successful. Exposure encourages habituation, avoidance increases fear.

Now let us consider this at the level of society. The more we spend on reassuring the public about increasingly implausible threats, the more anxious they become, and the more convinced that the implausible is just around the corner. As political scientist Bill Durodie has frequently said the precautionary principle makes more political than psychological sense (Durodie, 2002). Excessive reassurance about increasingly virtual risks does not work. Reassurance must be accurate and specific, or it may be counter productive.

Short and long-term responses

We are constantly told that with terrorism it is not a question of ''when, but if''. So let us now consider the scenario that an attack has indeed happened. What happens next?

Short term

I predict that the acute scenario will be relatively well managed. Contrary to the gloomy predictions beloved on television docudramas, there will be little panic. Heroism and altruistic behaviour will be commoner than we imagine. We will muddle through, creating a new set of cultural heroes and stereotypes as we do. And that in itself is important – populations under stress need heroic models to pattern their own responses and behaviours. Our emergency services will be visited by the Prime Minister and praised for their undoubted and predictable heroism and dedication. There will be an orgy of ''Lessons Learned'', but quietly planners will congratulate themselves and feel ''it could have been worse''.

But what about the psychological consequences – are there things we should be doing that will decrease psychological distress?

Whether we like it or not, almost before the blue lights stop flashing, the call will go out for counsellors, or ''trained counsellors'' as they are inevitably called. And they will respond with the usual intervention – some form of rapid psychological debriefing, defusing, critical incident stress debriefing or whatever it is being called at the moment. This would be fine if it works, but unfortunately it doesn't. Randomized controlled trials leave little doubt that immediate post trauma counselling does not reduce psychological distress (Wessely *et al.*, 2000). And there is some evidence that it may make some people worse (Emmerik *et al.*, 2002), especially if it is linked with promoting emotional ventilation, as it usually is (Sijbrandij *et al.*, submitted). Perhaps by promoting the idea that without it large numbers of people will develop psychiatric disorder, or by impeding our natural methods of coping by talking to family and friends. Or perhaps it is not always ''good to talk'' – some find it too painful or intrusive, others prefer emotional reticence over disclosure, even if that is currently unfashionable. The reason for the failure of debriefing can, however, be left to academics to determine – what matters is to recognize that immediate counselling of normal people who have been exposed to adversity does not promote resilience (Gist & Woodhall, 1999; Gist, 2002).

Instead, a wealth of evidence attests to the fact that emotional support comes from a person's own informal social networks – family, friends, colleagues, family doctor, priest etc.

These are people who knew us before the trauma, and will know us afterwards. When people are asked what they actually want after exposure to adversity, they inevitably respond that the first thing is practical support, and the second is to talk (or occasionally not talk), to family, friends, and colleagues. Professionals come low down on the list (Greenberg *et al.*, 2003). I suggest that one of the principal tasks of the authorities after a CBRN incident is to facilitate people talking to each other, and not replace it with ersatz ''friends''[1].

So should we do nothing? No. There is much that can be done to reduce psychological distress and promote resilience/coping. In brief these interventions are more practical than emotion based. The account given by US army psychiatrist Cameron Ritchie of immediate support in the aftermath of the September 11 attack on the Pentagon gives an elegant description of the provision of practical help. She describes how each bereaved family was assigned a ''casualty assistance care officer (CACO)'', who stayed with the family to help them negotiate all of the financial and other issues related to sudden death (Richie *et al.*, 2005). It is this type of ''nuts and bolts'' help which is the immediate and most pressing priority, and is itself a mental health intervention in all but name.

First, and foremost comes the provision of information. Lack of information promotes anxiety, knowledge promotes coping. Rumour, myth and panic flourish in information vacuums. Few will need persuading that the provision of timely and accurate information is vital – but many may be unaware that it is in itself a powerful mental health intervention.

Second, mental health support also comes indirectly from practical support. In the immediate aftermath what people need is security, warmth, shelter, and most of all, communication, as American psychologist Jamie Pennebaker has shown (Pennebaker & Harber, 1993; Mehl & Pennebaker, 2003). Communication of factual information must come from the authorities (and hence must be accurate), but emotional communication may best come from a person's own social networks. Anything that can be done to maintain these will foster social resilience, reduce panic and protect mental health. We know that the first response most people make to an acute adverse event is to attempt to communicate with their loved ones. Research from Israel on behaviour after terrorist incidents shows that provided this happens, people are then able to continue their lives, but if it is blocked, then they become more anxious and behave differently. There are some reasons why the authorities might wish to reduce the public's use of communications, especially mobile phones, in the aftermath of a terrorist incident, but the advantages of this should be set against the disadvantages in terms of promoting resilience. The current UK policy of insisting that people refrain from using their cell phones in the event of an emergency needs to be replaced by encouragement to ''keep it short''.

We can also be confident that the majority of those seeking medical aid after a CBRN incident will not directly require medical attention, but are doing so because of anxiety, uncertainty over perceived symptoms, or general health concerns. Estimates vary, but most assume that these numbers will exceed those directly affected by an order of magnitude (Stein *et al.*, 2004). It is very unlikely that stretched emergency services will be able to cope with these numbers, especially if the hospital services themselves are in ''lock down'' because of contamination risk.

These people also have information needs, which are unlikely to be met unless preparations have been made. Thought should be given to stockpiling simple information cards to be available via (or perhaps outside) hospitals with information on likely emotional reactions and how people can manage these themselves.

Longer term

And then what? Things settle down. Buildings are decontaminated. The underground train service is re-opened. The vaccination programme is no longer needed. Psychiatrists and psychologists may well now be needed for the small minority who have developed psychiatric disorders, but will probably be hard to find. Nevertheless, memories fade, time moves on, and there will be a collective sigh of relief from the rest of us outside the immediate vicinity. And then someone in the affected area has a miscarriage, gives birth to a handicapped child, develops a cancer, or just starts to feel unexpectedly exhausted.

And here we go again. What are they not telling us? Is it really safe? Can we trust the government scientists? Or should we trust that charismatic maverick scientist who tells us that the levels aren't safe at all, and who now seems to be commanding almost unlimited coverage? Is there a cover up? It's happened before, people say. Remember Gulf War Syndrome, MMR, BSE, the Amsterdam El Al crash, Camelford, Chernobyl and so on and so forth, going back to Agent Orange or the alleged cover up of nuclear test volunteers. And now up goes anxiety, down goes confidence, up goes symptoms and down goes trust. This is the scenario that causes so much disquiet and discord, and can indeed sap resilience and trust, whilst inevitably increasing symptomatic ill health (Hyams *et al.*, 2002; Engel *et al.*, 2002; Hassett & Sigal, 2002).

There is no simple solution to this scenario. However, it will be easier to manage if:

(i) During the acute crisis the authorities were perceived as being as open as possible commensurate with security.
(ii) That whatever the risk, it is seen as being equitable – that the authorities are responding fairly – and not, for example, seeming to discriminate between poor postal workers and comfortable information rich Congressional staff.
(iii) That at least some attempts were made during the acute incident to maintain a register of who was, and who was not, exposed.
(iv) That the authorities have a programme of sensible research in place from an early period, and not in response to later public/media pressure.

It is this situation that most taxes the authorities. So my prediction is that after a CBRN attack the acute effects will be less than we fear, and the long-term effects more insidious and difficult to manage that we imagine.

Note

1 Of course there are some who do not have their own sources of social support, and others who are too distressed to access them. But we must remember these are the exceptions, not the rule. Likewise, the post 9/11 oft repeated statement that special attention must be paid to deprived groups such as ethnic minorities seems to be based on the debatable assumption that ethnic minorities ipso facto have less natural social support and informal social networks than the more economically advantaged. Money can buy you lots of things, but lack of money does not necessarily mean lack of friends or family.

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