# Terrorism and its effects on mental health

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"Thou shall not kill", yet wars remain conspicuously present in the world map, as noted by Murthy and Lakshminarayana in their paper. Obviously, neither it is death the sole result of wars – psychiatric morbidity and disability are among the many outcomes of armed conflicts – nor the victims are confined to the military. Civilians, who are not spared the horrors of wars, are the prime targets of the horrors of terrorism. Indeed, terrorism is a hostile activity that is primarily aimed at civilians, with the purpose of advancing a specific agenda, political or other. Sadly, terrorist attacks, more than wars, are now claiming visibility in the news headlines in most regions of the world.

Mental health researchers are exploring the effects of terrorism on the individual and on communities. While some highlight the psychopathological effects of terror (1), others focus on the human suffering, which is not synonymous of psychiatric morbidity (2), and on community and cultural factors that enable withstanding the stressful event (3). This conflict between two polar approaches (2) has yet to be bridged. While open, the conflict grants the benefit of neither leading to conclude too prematurely that direct or indirect psychiatric action is to be ruled out, nor that the sole target of the interventions is the individual. A balanced approach may be advisable. The World Health Organization (WHO) has issued guidelines for action during emergencies which seem to endorse such a stand (4).

The fact that "someone experiences or witnesses an act of violence" does not mean that he or she "will inevitably

develop psychiatric morbidity" (5). After the September 11, 2001 attacks in New York City, it was noted that "in the aftermath of terrorist attacks, many Americans... regarded their distress as a 'normal' reaction" rather than "a disorder needing [psychiatric] care" (6). Bleich et al (7), in a survey conducted during intense terrorist attacks in Israel, found that post-traumatic stress disorder (PTSD) rates were unexpectedly low, 5.3%, although threats and losses were sustained by the population country-wide. An investigation on the use of services in Jerusalem during a period in which terrorism escalated, 2000-2004, found that city residents did not favor consultation with free and highly accessible psychiatric services, but instead turned to the general practitioners and the national telephone hotline for support (8).

What the currently available evidence seems to suggest is that it takes more than the agent (e.g., threat to life) to provoke psychopathology. Indeed, the role of the environment is of importance, a component of the epidemiological triangle that has been neglected by a greater focus on host-related factors (e.g., gender or age of the victim). Solomon and Laufer's study on adolescents (9), and those by Shalev et al (10), Kaplan et al (11) and Billig et al (12) on adults, have identified a group of factors, including religious beliefs, ideological commitment and social capital, that have protected communities which were highly exposed to terrorist attacks causing loss of dear ones, physical injuries and property damage. On the other hand, it is not redundant to notice that "Ideology and religious commitment also have a darker side. ...The most centered you become in your group, the less you are open to other ideologies or religious ideas. Thus ideology and religion may be used as a healing power, but also as a weapon. This is especially true in our [Middle East] region." (13).

Murthy and Lakshminarayana's paper leaves us partially hopeful that, by advancing research on the mental health effects of war-related activities, psychiatrists are joining the call by WHO member states to devise means to repair the psychopathological damage sustained by victimized populations. However, there may be other tasks for our field. Even at the risk of raising idealistic initiatives that skeptics would prefer to dismiss, one wonders whether what Murthy and Lakshminarayana have proposed is all what psychiatrists could do. There are many other possibilities open for psychiatrists who by the nature of their profession walk the path of health and peace rather than of war. Psychiatrists and other mental health professionals from countries in conflict may engage in collaboration in a number of endeavors (e.g., teaching, exchange of experiences in program development and services, communication), while they are actively, stubbornly and continuously supported by WPA. Importantly, their efforts may contribute to make their societies even more keenly aware that in armed confrontations no one is a winner but that everyone is a victim. The model of collaboration in the Balkans, where mental health is a bridge to reconciliation within the framework of the "Stability Pact", is a concrete example of what could be achieved when a unifying language is spoken, and when such an effort is buttressed by committed support from sources that are not part of the conflict.


## Acknowledgement

J. Levav reviewed an earlier draft of this commentary.


## References


1. Galea S, Ahern J, Resnick H et al. Psychological sequelae of the September 11 terrorist attacks in New York City. N Engl J Med 2002;346:982-7.
2. Wessely S. War and the mind. Psychopathology or suffering? Palestine-Israel J 2003;4:6-16.
3. Hobfoll S. Been down so long it looks like up. Palestine-Israel J 2003;4:17-23.
4. World Health Organization. Mental health in emergencies: psychological and social aspects of health of populations exposed to extreme stressors. Geneva: World Health Organization, 2003.
5. Curran PS, Miller PW. Psychiatric implications of chronic civilian strife or war: Northern Ireland. Adv Psychiatr Treatment 2001;7:73-80.
6. Drus BG, Marcus SC. Use of psychotropic medications before and after Sept. 11, 2001. Am J Psychiatry 2004;161:1377-83.
7. Bleich A, Gelkopf M, Solomon Z. Exposure to terrorism, stress related mental health symptoms, and coping behaviours among a nationally representative sample in Israel. JAMA 2003;290:612-20.
8. Levav I, Nobikov I, Grinshpoon A et al. Health services utilization in Jerusalem under terrorism. Am J Psychiatry (in press).
9. Solomon Z, Laufer A. In the shadow of terror: changes in world assumptions in Israeli youth. In: Danieli Y, Brom D, Sills J (eds). The trauma of terrorism: sharing knowledge and shared care. An international handbook. New York: Haworth Press, 2005:353-64.
10. Shalev AY, Tuval-Mashiach R, Hadar H. Posttraumatic stress disorder as a result of mass trauma. J Clin Psychiatry 2004;65 (Suppl. 1):4-9.
11. Kaplan Z, Matar MA, Kamin R et al. Stress-related responses after 3 years of exposure to terror in Israel: are religious-ideological factors associated with resilience. J Clin Psychiatry 2005;66:1146-54.
12. Billig M, Kohn R, Levav M. Anticipatory stress in the face of forceful removal of Israelis from Gaza. Submitted for publication.
13. Laufer A. Psychological growth in the aftermath of terrorist attacks. Palestine-Israel J 2003;4:30-6.