PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

Australian Guidelines for the Treatment of
Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types
Terrorism and trauma reactions

This *Terrorism and trauma reactions* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with people affected by terrorism. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*: www.phoenixaustralia.org/resources/ptsd-guidelines/.

Note that this information sheet does not provide detailed guidelines for disaster response more broadly in the context of a major terrorist event (e.g., a bombing affecting large numbers of people), and interventions for the whole population, such as psychological first aid, are discussed only briefly. Rather, the primary focus is issues affecting the minority who go on to develop long-term mental health problems. Under the auspice of the Australian Government Department of Health and Ageing, the National Mental Health Disaster Response Committee has been established to inform planning, preparation, rescue and response, as well as the recovery period in terms of mental health.

Background issues

There have been several attempts to develop precise working definitions of terrorism.[1] A proposal to the United Nations provided the following brief legal definition: "[an act of terrorism is] the peacetime equivalent of a war crime". [2] More precise definitions of terrorism tend to be relative, because judgments about acts of political violence are often subjective. For example, the United States Department of Defense[3] defines terrorism as: "The unlawful use of violence or threat of violence to instill fear and coerce governments or societies. Terrorism is often motivated by religious, political, or other ideological beliefs and committed in the pursuit of goals that are usually political". Although more comprehensive, this definition is problematic because it relies on vague terms which are left open to interpretation (such as "unlawful violence" or "the pursuit of goals..."). Put simply, one person's terrorist is another's freedom fighter. In some cases, this ambiguity can make it more difficult for survivors to understand and find meaning in the experience.

Terrorist acts usually involve the threat of (and sometimes actual) high levels of destruction to property and, more importantly, to people. There is likely to be widespread threat to life and actual loss of life. There may well be exposure to gruesome sights for those involved, including the death and suffering of others; this may include close family members and friends. Difficulty (or inability) in helping others in the aftermath of the attack may precipitate feelings of helplessness and guilt.

The fear generated by terrorist attacks is unsurprising; they are characterised by many features typical of high severity traumatic events. Terrorist acts are generally unpredictable in terms of place, timing, and potential victims; as such, they are completely uncontrollable (at least for the general population), increasing the risk of perpetual hypervigilance. Bioterrorism carries added threat since it is so poorly understood and is, effectively, 'invisible'. It is hard to be definite about whether an individual or group has been 'contaminated' and, even if individuals have clearly been exposed to pathogens, the likely health effects are rarely clear.

It is important to remember that the main goal of terrorism is exactly that – to generate feelings of terror in the community. Acts of terrorism are extremely rare (particularly in Australia) and the effects of fear and hypervigilance are often well in excess of the actual damage posed by, or caused by, the terrorist act.

In short, terrorist acts are generally high magnitude traumatic events, of very rare occurrence, capable of generating widespread fear and hypervigilance. For mental health professionals, this raises questions as to the best way to prepare for such attacks and the best way to manage the mental health consequences.

Issues for service planners

Preparing for the threat of terrorism

Reactions to terrorism can be made worse by sensational media reports and by poor communication by public officials. Thus, a key role for mental health professionals is often that of working with the media and public officials to ensure that appropriate messages are disseminated. Communications to the general population should be informed by the following recommendations adapted from Foa et al.[4]

- Provide realistic information on the likelihood of a terrorist attack and possible impact.
- Communicate that the individual risk is quite low.
- Explain that negative health behaviours which may increase during times of stress (e.g., smoking, unhealthy eating, substance use) constitute a greater health hazard than the hazards likely to stem from terrorism.
- Emphasise that the only action required on the individual level is increased vigilance of suspicious actions, which should be reported to authorities.
- Clearly communicate the meaning of different levels of warning systems.
- When issuing a warning, specify the type of threat, the type of place threatened, and indicate specific actions to be taken.
- Make the public aware of steps being taken to prevent terrorism without inundating people with unnecessary information.
- Provide the public with follow-up information after periods of heightened alert.

Communications by the media and public officials should also include simple information about resilience and expectations of recovery. Many simple fact sheets on resilience in the face of terrorism are available on the internet.

Responding to an attack

It is important to remember that most people will recover without any mental health assistance; thus, interventions in the early aftermath of a terrorist attack should be based around providing information and activating community support.

- Support the work of the emergency services.
- Activate and facilitate community support networks.
- Provide accurate information about the event and its consequences.
- Facilitate accurate and balanced communication by the media, schools, workplaces, etc.
- Establish information and drop-in centres to provide information, support, contacts, etc.
- Promote opportunities for mutual support through education and information, as well as by facilitating appropriate social activities through workplaces, schools, sports clubs, churches, and other community agencies.

Although debate exists in this area, it seems reasonable to implement some kind of low-key screening to facilitate identification of those individuals who are not showing the normal recovery trajectory and who are developing identifiable mental health problems. This might be done as part of a public health approach ("*…if you are experiencing several of these symptoms, we suggest you visit your local GP*") or in a more restricted manner (such as through advertising telephone numbers for trained personnel to conduct screening). (See Brewin et al.[5] for an example following the 2005 London bombings.) The key point is that secondary prevention – early intervention for individuals with mental health problems following trauma – is demonstrably effective, if they can be identified. This approach requires that educational material is made available to general practitioners to ensure that appropriate assessment, education and advice is forthcoming.

Issues for service providers

Presentation

An attack of small to moderate impact is likely to generate moderate to major psychological and behavioural reactions in the short term, and the greater the harmful impact of the attack, the greater the likely reaction. Proximity to the attack and number of attacks will influence the severity of individual reactions. There is no reason to assume that the nature of clinical reactions, when they occur, would be significantly different to those seen following other types of traumatic events.

Immediate reactions are likely to include heightened anxiety, panic attacks, sleep and substance use problems, absenteeism from work, and retaliatory reactions against minorities identified with the terrorists. Reactions are likely to subside over the medium term (days to weeks), although repeated attacks and/or widespread loss of life and/or significant damage to infrastructure may result in increased psychological and behavioural reactions.

Significant longer-term mental health reactions are likely to be limited to a relatively small proportion of the population. These reactions may include traumatic stress symptoms, other anxiety disorders, depression, and substance use, all of which may be associated with impaired functioning and increased distress. The ongoing fear of another attack is likely to pervade all reactions to a greater or lesser extent.

Assessment

Standard approaches to assessment should be applied when assessing people presenting for treatment following a terrorist attack.

Treatment

Several 'real world' effectiveness trials of PTSD treatment following terrorist acts have appeared in the literature, including programs in Northern Ireland, the United States, and the United Kingdom (e.g., [5,6,7]). Each of those programs utilised cognitive behavioural approaches, training local clinicians in the delivery of evidence-based PTSD treatment. In each case, the outcomes were impressive. Thus, there is no reason to assume that interventions for those developing PTSD and related conditions following terrorism should be any different to those recommended for other trauma survivors. The recommendations provided in the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* should be considered as the starting point.

The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. **Grade B**
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**
- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**
- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**
- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

Working with children

As with adults, the range of children's responses to terrorism is highly variable and psychological reactions will be strongly influenced by the behaviour and reactions of primary caregivers.[7] Also consistent with adults, there is no reason to assume that treatment should be any different to those applied for PTSD of other origins. It is, of course, vital that clinicians are competent and experienced in working with the particular age group, and close attention should be paid to advice regarding treatment of children provided in the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (2013).

With that caveat, children and young people with PTSD following terrorism should be offered a course of trauma-focussed cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development.

The key recommendations, graded B through D depending upon the strength of the evidence, are:

Psychological interventions for children and adolescents

- For children exposed to a potentially traumatic event, psychological debriefing should not be offered. **Grade B**
- For children of school age and above with PTSD, developmentally appropriate trauma-focussed cognitive behavioural therapy should be considered. **Grade C**
- For children exposed to trauma with symptoms of PTSD, where they were exposed to the same event, a school-based trauma-focussed cognitive behavioural intervention aimed at reducing symptoms of PTSD should be considered. **Grade C**

Pharmacological interventions for children and adolescents

- For children exposed to a potentially traumatic event, pharmacotherapy should not be used as a preventive intervention for all those exposed. **Grade D**
- For children and adolescents with PTSD, pharmacotherapy should not be used as a routine first treatment over trauma-focussed cognitive behavioural therapy. **Grade D**
- For children and adolescents with PTSD, pharmacotherapy should not be used routinely as an adjunct to trauma-focussed cognitive behavioural therapy. **Grade D**

Recommended reading

Ursano, R. (Ed.). (2003). *Terrorism and disaster: Individual and community mental health interventions*. New York: Cambridge University Press.

Ursano, R., Fullerton, C., Weisaeth, L., & Raphael, B. (2011). *Textbook of disaster psychiatry*. New York: Cambridge University Press.

Source and contributors

This information was taken from the Terrorism section (p.167-174) of the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Terrorism section was developed by Phoenix Australia in collaboration with Professor Mark Creamer, Clinical Psychologist, Department of Psychiatry, University of Melbourne.

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7. Levitt, J. T., Malta, L. S., Martin, A., Davis, L., & Cloitre, M. (2007). The flexible application of a manualized treatment for PTSD symptoms and functional impairment related to the 9/11 World Trade Center attack. *Behaviour Research and Therapy*, 45(7), 1419-1433.

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