Psychological Aspects of Terrorism

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It used to be fairly common, but now hardly a day goes by without someone asking "You're a psychiatrist—so tell me, what makes people become terrorists?" or "What's wrong with those people?" My answer in this month's column is the same as it has always been. First, there are many different kinds of terrorism and terror-violence (a term coined, or at least popularized, by Professor M. Cherif Bassiouni of Loyola School of Law, Chicago). The "answer," to the extent that anyone knows it, varies from type to type and event to event. Second, although everyone has a personality, and personality is important in behavior, the idea that there are archetypal terrorist personalities, or mental illnesses that predispose one to what most people call terrorism, is simply a myth.

For these reasons, this month's column may not sound very psychiatric at times. I will talk more about what terrorism is not (*vis-à-vis* psychiatry and psychology) than what it is, in an effort to help readers understand that psychiatry, for the most part, should not be expected to have many answers to this vexing problem. Issues specific to psychiatric treatment, such as how terrorist actions can be addressed in the psychotherapeutic relationship and the management of trauma and disaster in psychiatrically vulnerable populations, are discussed elsewhere in this issue.

This column will refer to terror-violence aimed at groups rather than individuals (although particular events may, of course, have one physical victim). I will not discuss hostages taken during ordinary robberies or isolated incidents of violence spawned by delusion or paranoia. Instead, I will talk about people who are not part of a national military force, use a pattern of sudden violent or fear-inducing action against civilians, and are not in a declared war between nations.

Despite its apparent vagueness, this definition is important if we are to avoid confusion and focus our topic. The definition omits wars, no matter how cruel. It does not include torture of state-held prisoners, even though many would call such actions terroristic and all would call them despicable. "Revolutionary" acts are excluded so long as they are organized against military targets. I will try to avoid the conundrum of "one man's terrorist is another man's freedom fighter," as expressed by Professor J. K. Zawodny, an expert on terrorism and a former Polish freedom fighter.

Psychiatric Models Have Limited Utility

Some 25 years ago, Dr. Frederick Hacker gave a psychiatrist's view that terrorism could be divided into, as the title of his book suggests, "Crusaders, Criminals, and Crazies." He viewed most events similar to the September 11 tragedies and embassy bombings as being carried out by "crusaders," or people working for a political or philosophical cause, then made them psychological by referring to things like "grandiose identification with a sacred cause and its representatives" and "giving up… individual responsibility, and individual interest, experience[ing] the 'high' of 'liberation' from… individual problems, guilts and anxiety."[1] That seemed to make sense; it gave people a sense of knowing what they were doing, and the principle of "the three Cs" survives to this day.

Two decades ago, the American Psychiatric Association developed a task force that worked briefly with government agencies and produced a small volume on terrorism and its victims.[2] The consensus of the task force and those with whom we worked was that, with some highly specialized exceptions, psychiatry's roles and expertise are primarily in victim care (and sometimes, when mental illness is a factor, perpetrator assessment or treatment).

Hacker's categorization and the work of a few social scholars (such as the RAND Corporation's Brian Jenkins) may have some utility, but it is important to realize that most terrorists, according to the definition given earlier, are not mentally ill and probably don't have any more psychological flaws than most criminals (often fewer). Their behavior is vexing and often inexcusable, but they should not be confused with people whose

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emotional status creates some legitimate rationalization of, much less exoneration for, their behavior.

Suicide Bombers Aren't Hard to Find

One of the things that amazes people most—and engenders questions for psychiatrists and psychologists—is the phenomenon of so-called "suicide" terrorists. They seem foreign to our culture and make us feel helplessly vulnerable. We should not find them so amazing, or so surprising. There are many ways to get people to die in the service of some goal; one is religious promise for devout believers, even though this can be difficult for nonbelievers to imagine. Patriotic fervor is another. Others include offers to pay the person's family if the mission succeeds, threats to harm the family if the mission fails, and finding perpetrators with terminal illnesses. Intoxication and psychological preparation (such as hypnosis, "brainwashing," or operant conditioning), although popular in films and accounts of Japanese *kamikaze*, are scenarios that should be left to the movies.

The Practicality, and Failures, of Terrorist Behavior

There is little that is unique about terrorist behavior. It has been with us for centuries and is a time-worn practice. It has a utility that overshadows the social theories discussed in journals and the media, and it outstrips the psychological theories of academics who, although taken more seriously a few decades ago, are now mostly confined to academia, think tanks, and opinion pieces. We have had to become more practical.

The terrorist and his organizations have always been practical. They use principles that date to hundreds of years before Christ. If one views their goal as the overthrow of governments or the creation of broad social change, they have usually failed. If, however, one views their goals as disruption, deflection of purpose, drain on resources, attention gathering, and/or organizational profit, then we must admit their potential for success:

- ***Disruption.*** Creating chaos, fear, confusion; making routine activity difficult.
- ***Deflection of purpose.*** Causing the target group or population to stop routine activities and focus on the terrorist act and related issues.
- ***Drain on resources.*** Causing resources ordinarily used for routine activities to be diverted to deal with the terrorist activity or its victims.
- ***Attention gathering.*** Bringing attention, notoriety and, for some, a level of validity or definition to the terrorist group, often implying a sort of "marketing" to achieve legitimacy or authority. (Note that the attention is not usually focused on the terrorists' espoused cause, but rather on the terrorists themselves.)
- ***Organizational profit.*** A great deal of terrorism that cloaks itself in a crusade is more accurately seen as criminal activity. Even groups that say they eschew capitalism spend much of their energy raising funds and using money gained from capitalist endeavors. State sponsorship is a primary source of terrorist funding and operating ability. The leader or group that speaks loudly of a social or religious purpose is often actually performing a task-for-hire (and perhaps rationalizing its criminality and entrepreneurship with pious rhetoric). Terrorism, like organized crime, is often big business.

Controlling Terrorism

Changing the environment that is being attacked to fit the terrorist's demands—that is, mollifying the terrorist—is not a reliable way to change terrorist behavior. Control of terrorist behavior lies, rather, in 1) weakening or eliminating the terrorist himself; 2) controlling, "hardening," or eliminating routes of terrorist attack; 3) decreasing terrorist funding and sponsorship; and 4) making the terrorist's goal too expensive to pursue.

The first strategy, eliminating the terrorist himself, is difficult (although not always impossible). While some organizations may depend on a particular leader and be vulnerable to "cutting off the head of the viper," older and more well-developed groups are more like a hydra (the mythical monster who, when its head was cut off, simply grew several more) than a viper. In addition, simple but effective organizational structures similar to the interlocking "cells" of 1950s U.S. Communism (and, before that, World-War II underground organizations) create few vital points for attack.

The second approach, controlling or eliminating routes of attack, is perhaps the most common one. It includes decreasing terrorist effectiveness by measures such as predicting targets, making targets more difficult to damage or reach ("hardening"), lowering their terrorist "value," and keeping effective weapons out of terrorist hands.

The third approach takes advantage of the knowledge that funding and sponsorship are very important to (especially large-scale) terrorist operations and to their ability to shelter their members. Economic measures such as interrupting cash flow and curtailing funding and banking mechanisms are being highlighted in our current "war on terrorism." Decreasing local and popular sponsorship (e.g., through education or propaganda, providing humanitarian aid, rewarding those who fight against the perpetrators, or punishing those who support or shelter them) is often effective.

The fourth approach, making terrorist action more and more expensive, includes some elements of the first three strategies but deserves separate mention. Some terrorist

acts cost the organization little at first, but if diligent law enforcement leads to the perpetrators' imprisonment, loss of organization funding, or ostracism by the sheltering country, the simple act becomes much more expensive. In another example, when sophisticated weapons become available to the highest bidder, countries such as the United States can purchase them at inflated prices, not only to keep them out of the wrong hands, but to raise the price so much that few can be bought by terrorist groups.

Fears of Angering the Perpetrators

Some people view aggressive antiterrorist action as likely to make matters worse by further angering people who are already angry at their victims. A minority of Americans believe we should stop our own actions, lest they ignite reprisals. Many more fear reprisal, but accept the need to act aggressively.

Those who express strong opposition to taking legitimate, aggressive (in recent weeks, violent) action in an effort to decrease future terrorism are generally, in my view, either ill informed or acting on a personal or self-serving impulse. First, neither history nor experience suggests that mollifying aggressors is helpful. Whether one examines the British and U.S. reactions to Hitler's expansion during the 1930s or the microcosm of dealing with an abusive parent or spouse, recognizing the need for definitive action and rapidly carrying out that action are critical in decreasing the ultimate violence and minimizing the ultimate damage. Although never to be entered into lightly, the adage that "violence never solved anything" is just not true.

Second, while we can understand feelings of fear or hopelessness, including, for example, concerns about one's children being in the military and sent into harm's way, it is a mistake to act on those feelings if the actions run counter to the need to stop a serious threat. Immediate impulses to stave off pain or danger may be far less important than longer-term consequences of running from the fray.

Defining and Helping Victims of Terrorism

Until September 11, 2001, U.S. civilians felt insulated from most effects of terrorism, even though injury or death from terrorist acts against foreign-based U.S. targets had become a fairly frequent occurrence. Victims have sometimes been part of a larger U.S. target (e.g., recent embassy bombings, last year's bombing of the USS Cole in Yemen); sometimes they have been sought out individually; and sometimes they have been caught coincidentally in an attack on a non-U.S. target. Before September, the number of terrorist incidents in which U.S. citizens were victims had increased from 274 in 1998 (in which 741 U.S. citizens were killed and 5952 wounded) to 392 in 1999 (in which 706 were killed and 233 wounded).[3]

In many forms of terrorism, such as anthrax mailings and bombings of abortion clinics, the perceived threat is much greater than the actual danger. The ancient axiom "Kill one, scare 10,000" works well to frighten, and thus to victimize, with little expenditure on the part of the terrorists. As we now know, the "scare" value of real and implied threats is increasingly accompanied by the prospect of real destruction, but the risk of widespread devastation remains very small.

One may consider several levels of victim, arranged in a pyramid with a widening base. At the top are people who have been physically attacked, injured, or killed. Just below them is another level of individuals who have suffered immediate and direct loss, such as the families and neighbors of victims. Below that, one finds people who have been less directly affected but who have experienced some significant change in their lives (e.g., friends, rescue workers, employees of damaged businesses). Lower, broader parts of the pyramid are made up of people who are physically distant but particularly sensitive to environmental uncertainty (including some patients with psychiatric disorders) and, at the bottom, the masses of people who have made some change in their lives and/or experienced some level of previously unfelt fear as a result of the terrorist act. In medium- and large-scale attacks, such as those of September 11, one must include a layer of those affected, directly or indirectly, by business, government, or economic changes (e.g., effects on the airline and tourism industries, military activities, and some short-term stock investments).

The terrorist thus takes from us in a measure disproportionate to his actions. Many people who are at very low risk—certainly lower than their risk of automobile accident or cancer—suffer anxiety and depression, change their behaviors, experience fear or inconvenience, and expend additional physical and mental resources. Their worlds become less satisfying, and noticeably smaller.

Individual Victims. Understanding patterns of victim response can contribute to more effective care. General principles of disaster response apply to most situations (preparedness, understanding traumatic stressors and disaster response, recognizing high-risk groups among current victims).[4]

Acute reactions of victims are similar to those associated with other community disasters. Mental health responses should be expertly coordinated, and mental health professionals should cooperate with emergency response agencies and lay a foundation for more lasting support (e.g., from community mental health services). Training in victim support techniques is important, and available from a number of organizations.

Very recent victims require special understanding. One may start with a gentle approach, offering basics such as food and a soft word. The kind of terse questioning often seen in "debriefing" should be avoided. Therapists should not assume that they understand the victim's feelings.

They should have counseling skills and experience, not merely sympathy for, or identification with, the victim.

Victim Adjustment and Recovery. The intensity of trauma is directly related to the intensity and duration of its effects. Very intense victimization, particularly physical injury, has a stronger effect on long-term adjustment than moderate or minimal victimization during the same traumatic event.[5]

In ordinary, non-terrorist disasters, the majority of victims recover without long-lasting substantial post-traumatic effects,[6] although media exposure and personal injury litigation can exaggerate both perceived symptoms and claims of distress. Victims of terror-violence fare less well on average, although most, even with physical injury, have good emotional recovery.[7]

Victims' Families. Families of victims are victims as well. Families of hostages, for example, suffer acute trauma and sometimes chronic adaptive syndromes. Release of hostages after long periods often brings unexpected problems, including guilt about feelings and behaviors while the victim was away, disruption of family equilibrium, and denial of the many issues that must be faced after release. Divorce is extremely common.

Rescue, Military, and Law Enforcement Personnel. Those who deal with terrorism and its aftermath become victims as well. Qualified intervention with rescuers, post-shooting counseling, and other kinds of help by experienced professionals, sometimes as simple as stress management, are important.

Effects on Patients.

A patient with chronic mental illness was presented to a psychiatric case conference shortly after the September 11 tragedies. She had become acutely psychotic and severely agitated, believing that those around her were part of an international terrorist threat and would try to infect her with anthrax. The conference discussion included the role of the terrorist events in precipitating this exacerbation of her symptoms, the probability that any event so striking would be reflected in her delusional system, and the extent to which any new and substantial stressor might have threatened her tenuous hold on reality.

A brief survey of clinicians at the conference indicated that at least half those present had noticed unusually severe reactions to the September 11 events and related media coverage among some of their patients.

Effects on Clinicians and Trainees. Psychiatric facilities and mental health centers, especially those in the public sector, employ and train a great many clinicians from other countries. It is important to recognize the effects of recent events on middle-eastern (including Pakistani) and Muslim clinicians in the United States. A discussion of the September 11 events with a group of state hospital medical staff and trainees revealed mixed experiences and reactions. Many of those of middle-eastern descent were concerned about neighborhood and community suspiciousness and misguided reprisals (citing vandalism at a local mosque and media concern about stereotyping), but few believed their patients were treating them differently. Even psychotic patients, with a few exceptions, viewed these clinicians as individuals and doctors, not stereotypic middle easterners or Muslims.

Several mentioned that their patients did not seem to differentiate middle-eastern clinicians from those of, say, Indian or South American backgrounds, and were accustomed to seeing darker-skinned professionals. (It should be noted that all of our discussants typically wear western clothing, and none has a beard. Some have fairly distinctive facial features or accents.) Some of the discussants agreed that their own reactions might reflect some denial or rationalization; nevertheless, continuing inquiries over the next few weeks did not suggest many problems.

The Last Word

For psychiatrists and other mental health professionals, the most pertinent "psychological aspect" of terrorism has to do with its victims. For more detailed discussions of how terrorist issues affect the therapeutic relationship and the treatment of psychiatrically vulnerable patients, readers are referred to the Psychotherapy column by Clemens and the Road Back column by Pandya and Weiden elsewhere in this issue.

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