Exposure to repeated acts of terrorism: perspectives from an attacked community*

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The beginning of the new millennium has been characterized by the emergence of a new era of global terrorism. With approximately 3000 fatalities in New York City alone, the attacks of September, 2001 represented the largest single act of terrorism in history. While confined mostly to the Middle East before 2001, the Al Quaida attack on the USA marked the beginning of a new phase of radical Islamist bombings of Westerners in Bali, Istanbul, Madrid and London and with recently identified terror cells in Germany. How does a civilian population react when exposed repeatedly to similar events? The Israeli civilian population might be a relevant case study. This article describes scientific findings, clinical observations, and personal perspectives on the exposure of the Israeli civilian population to the 2000-2003 terror campaign.

Historical Background

The most recent hostilities Israelis have faced were the 2006 Hezbollah-Israel war in which 4000 rockets were fired on the civilian population and the 2001-2004 string of random terror acts against civilians and Israeli security forces, dubbed by the Palestinians the »Al-Aqsa Intifada«. According to a Shabac report (Israel's Secret service) published in Yediot Acharonot daily, (29.9.2005, p. 11). The Intifada violence entailed:

- 26159 recorded terror attacks, mostly shooting incidents;
- 144 suicide bombings (4 in 2000, 35 in 2001, 60 in 2002, 26 in 2003, 13 in 2004, 6 in 2005).

This campaign developed into a low-intensity war against a civilian population, the worst era of civilian bloodshed in the region's history. This surge of terrorism and the military force utilized to curb it represented an unparalleled threat to the two conflicted populations. The 2006 Hezbollah-Israel war provided yet another opportunity to study the reactions of civilians caught in the cross fire.

Type IV environment and civilian demoralization

Single stressor events potentially leading to PTSD (e.g., rape) was termed Type I trauma (Terr, 1991). Repeated trauma potentially leading to personality problems and dissociative disorders (e.g., incest) was termed Type II trauma (ibid.). Chaotic environments (e.g., intrafamilial or interpersonal relationships with high levels of inconsistency and unpredictability) were termed Type III by Berk (1992). He posited that Type III environments can also lead to the development of PTSD symptoms, dissociation, and personality changes. Wilson (1994) defined a separate category of stressors: Type IV stressors constitute an alteration in a person's basic relation to the environment due to exposure to anomalous events that produce high levels of uncertainty and profound adaptation dilemmas because victims are uncertain about effective ways to protect themselves. Wilson's term probably fits best the sort of stress Israelis have been facing during Intifada and the Hezbollah attacks in 2006.

Repeated random attacks on civilian centres by bombardments or by terrorism are strategies designed to create fear in the target population and meant to make people lose confidence in their ability to protect themselves effectively or in their government capacity to protect them. The intended result is to harm the enemy population and create a climate of demoralization and psychological injuries creating adaptation dilemmas akin to Type IV trauma.

Reports published during the beginning of the Intifada attacks indicated that as many as 80 % of Israelis feared that a terror attack could strike them or a member of their family (Jerusalem Post, 4 June 2001). The Peace Index Project conducted at the Tami Steinmetz Centre for Peace Research of Tel Aviv University published the results of a telephone survey conducted at that time (www.tau.ac.il/peace). They indicated that about one-quarter of Israelis aged 18-20 were actually considering emigration; to the question: »How would you describe your mood nowadays?« 38 % responded that it was medium and 31 % described their mood as bad or very bad (Yaar & Hermann, 2002). These figures obviously far exceed the number of Israelis who were terror victims and may reflect a morale index in-

Note

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dependent of direct exposure and reflecting one of the outcomes of the Type IV stressor environment that developed in Israel during that period.

What do we know of civilian reactions to terrorism? Some of the studies published following the September 11 attacks on New York City shed some light on this question. Schuster et al. (2001) conducted telephone interviews with a US national representative sample of 560 adults, 3-5 days after the attacks. Forty-four percent of the respondents, all over the country, reported distress and concern. Data released by US National Institute of Health showed increased consumption of cigarettes, alcohol, and marijuana nationwide (possibly reflecting self-medication) in the weeks following the attacks. Studies conducted closer the ground-zero revealed the magnitude of traumatic stress among the targeted civilians:

- Galea et al. (2002) interviewed 1008 Manhattan residents, 1-2 months after the attacks. Prevalence of PTSD was 7.5 % (20 % close to the World Trade Centre), and a 9.7 % prevalence of Depressive Disorders.
- Schlenger et al. (2002) interviewed adult citizens (using the internet) 1-2 months after the attacks. (Probable) PTSD was found in 11.2 % of NYC residents.

The nature of the Israeli stressor during the terror campaign was quite different, as articulated earlier. From the eruption of this terror campaign to the initial collection of data for this study, 653 terror attacks against Israeli civilians were launched. With a population of 6.5 million inhabitants, the casualty rate of 1047 individuals was massive (equivalent to 28,000 dead in Germany).

The degree of trauma exposure among Israelis residing in central and Northern Israel during the Intifada was as follows:

- 5 % were emotionally or physically injured by a terrorist attack;
- 20 % were present on the scene either during an attack or shortly before or after it;
- 22 % reported they had a friend or relative that was killed or wounded;
- 81 % were exposed to the damaged site shortly after a terrorism attack.

In addition to this first-hand experience with terror, exposure to media coverage was widespread and included virtually every individual we interviewed. Data from large-scale telephone interview surveys conducted following massive disasters (e. g., Pfefferbaum et al., 1999; Galea et al., 2002; Schlenger et al., 2002; Schuster et al., 2001) suggest that exposure to emotionally charged, real-life television images of death and destruction can produce symptoms of PTSD and depression in children and adults. Our data indicate that even in remote parts of Israel, PTSD symptoms associated with the terror campaign could be measured (Somer et al., 2005).

The unpredictable, perilous ecology that had characterized the environment during the investigated hostilities clearly qualify as a Type IV stressor, conducive to the development of various adaptation patterns, including variants of dissociative coping.

A plethora of posttraumatic stress symptoms was measured during the height of the Intifada in non-clinical samples:

- 55 % reported at least one Avoidance symptom;
- 50 % reported at least one Increased-arousal symptom;
- 27 % reported at least one Dissociative symptom (Bleich et al. 2003; Somer et al., 2007)

Dissociative symptoms are commonly observed among victims of Type I trauma. Indeed, peritraumatic dissociative responses were commonly shared by interviewed citizens in Israel during the height of the hostilities. Following are typical remarks by bystanders and survivors interviewed in the media shortly after having been exposed to the traumatic incident:

- »There was a flash of bright light and a huge explosion and than there was silence… I thought this cannot be happening…«
- »There was body parts scattered around… they did not seem to be human parts…«
- »I could not believe this was really happening…«
- »I thought I was in a movie. Nothing seemed real…«
- »It felt as if I was in a bad dream…«

These remarks illustrate consistent individual peritraumatic de-realization symptoms. Recorded hours following exposure to a potentially traumatic event, these experience are considered normal or even adaptive posttraumatic reaction and are unclassifiable psychiatrically. The unusual circumstances of the Intifada and the 2006 war provided me with the opportunity to experience the subject matter of my field of inquiry first hand.

Struggling with dissociation: A personal perspective

As a trauma clinician, I found this period unusual because I ceased to be the detached scientist, or the clinician who treats problems from the clients' past. I became a participant observer in an unfolding community drama. A victim-

scientist, victim-therapist, if you will. Like many Israelis, immediately following an attack my urgent need was to call my family and friends to make sure they were okay. My grown-up children have lived in two of the most targeted cities. Upon receipt of breaking news on another fatal attack, I often experienced briefly a sense of outrage at the senseless killing. It soon was followed by a blanket of numbness that accompanied my continuous compelling monitoring of online and electronic news channels. I found myself searching for pictures of the victims, looking for uncensored photos published on private Internet e-blogs. I remember e-mailing friends, expressing perplexity and concern about this troubling compulsion of mine.

It appeared that I was trying to immerse myself entirely into the horrific experiences of the victims, attempting to make sense of what they were going through. Was this the position of a scientist-practitioner making an attempt to comprehend the subject matter of his inquiry? It was clearly also an effort to fight my numbness. I dreaded the possibility that it might actually represent an unacceptable heartlessness. The tension between my fellow-feeling with the victims and my failure to contain their pain often resulted in a personal sense of despair and fateful resignation to our national legacy of suffering. Mine is an example of an ostensibly adaptive dissociative defence, which had created its own considerable discomfort. My derealizing numbness helped me continue with my research and clinical work as I compartmentalize my own fears and agony. But the same distance I developed from my battered environment also stood in dissonance with my need to identify with my attacked community and with my self-image as a caring individual. My compulsive vicarious exposure to the images, reminded me, at times, of my self-mutilating clients who are fighting the dialectic distressful blend of pain and numbness.

Dissociation among my collegues

One of the fruits of my frantic coping was several articles (e.g., Somer et al., 2004a) and chapters in the 2005 book Mental Health in Terror's Shadow: the Israeli Experience which I edited (e.g., Peled-Avram et al., 2005). In one of the book chapters we describe our observations on the stress of other mental health professionals under the duress of the terror campaign. When an Israeli hospital declares a state of alert in anticipation of mass casualties, the hospital's mental health staff deploys in the emergency rooms, in the surgical wards, and in specially set up computerized information centres to attend to the injured, the psychologically shocked, and the worried families in search of missing relatives. All professionals who are off duty and in their homes are immediately called in as well. We asked these first responders to describe their reactions when the hospital moved into emergency preparedness following a terror attack. The following list describes the main themes that had emerged from the analysis of their interviews:

- Being part of the attacked community means sensing the fear, the demoralization, the anger and the despair that terror is meant to induce.
- Role conflict: Shall I find out about the wellbeing of my loved ones or should I rush to my hospital duties immediately?
- Role conflict: Shall I try to calm down first or should I rush to my hospital duties immediately?
- Sensory bombardment with intense and unfamiliar stimuli: Dozens of ambulances, screaming, shouting, sickening smells and horrifying sights.
- The need to contain real tragedies (not those recounted in psychotherapy in retrospect).

When we asked them to describe their emotional reactions a consistent theme emerged from the disclosures of the Israeli clinicians: dissociation. Here are some representative quotes to illustrate our conclusion:

> »One woman called in to inquire about a couple I knew personally. This stressed me out so much I started to weep… I moved to the treatment centre to work with the arriving families and I'll tell you exactly what I did… Relatives of the missing were asked to help identify some of the corpses. Family members were wailing. This was a very scary experience. I suddenly went empty, I felt nothing, I was in shock [smiling], no, I'm not sure it was shock; it was as if I was outside myself. I took myself and put it aside and told myself that I had to do something and do it well…«

This clinician had been asked to assist a wounded community to which she belonged and which she was hurting with. In reaction to horror she was suddenly thrown into she described a spontaneous emotional shut down, and a dramatic depersonalization bordering on a structural personality tear. Her disharmonious coding of the stressful experience was evident in her dissonant smiling reaction during her description of her shocked reaction.

In the next quote one of the mental health first-responders spontaneously described a seemingly controlled adaptive dissociative reaction.

> »…the most meaningful thing I do [takes a deep breath] is that I emotionally disconnect… this emotional disconnection helps me not to break down in front of the traumatized families.«

This professional knows of her peritraumatic emotional turmoil and describes the necessity to curb it at once. It seems that this conflict is still present during the interview. As she is accessing the peritraumatic distress, painful feelings seem to emerge, which she attempts to control with a deep breath. The next passage describes clear dissociative psychopathology:

> »I was involved in three bombings… I am trying to recall my first experience following the suicide bombing at H. Junction [the event had occurred about seven months prior to the focus group interview]… I have no idea what my duties were, what families I worked with, how I functioned, nothing… but I do have memories of the next two disasters.«

This last quote demonstrates how traumatic the first exposure to emergency duties following a suicide bombing attack was. This hospital social worker had participated in three emergency mass-casualty deployments in 7 months. She had access to the details of her memories concerning events 2 and 3, but presented a full dissociative amnesia for a major dramatic event that she actively took part in only 7 months before the interview.

In a review of the literature on PTSD among emergency services personnel, Bamber (1994) highlighted the widely held idea that professional helpers are somehow immune to suffering the same sort of distress as those they are helping. Our findings show that this is by no means the case. The most prominent factor in the inability to maintain emotional distance between Israeli mental health workers and their terrorized clients was the fact that these professionals were integral elements of the attacked community. Not only were their cognitive schemas about safety threatened, their sense of personal safety was endangered as well. Workers needed to allay their fears and worries about the security of their loved ones before they were able to project themselves into their professional roles.

My own experience and the accounts of the psychotherapists I talked to reflect a paradoxical situation: Although we had been trained to respond in emergency situations and we were fairly knowledgeable about potential scenarios, we were overwhelmed by the sheer magnitude and swift onslaught of devastating sensory stimulation. Such human drama cannot be rehearsed in simulated situations – the sounds of wailing sirens, moaning patients, panicking relatives, and shouting staff, combined with the sight of bodily disfiguration and the unfamiliar, acrid smell of burnt flesh, remain an unrehearsed traumatic experience.

Discussing combat stress, Noy (1991) argued that there is a tendency for emotions to be exaggerated in a polarized manner. Similarly, Israeli mental health workers reported that they had experienced either no emotional stress or a severe level of stress. Only after they managed to shut out offensive elements of their reality they were able to muster their professional resources with a heightened sense of duty.

The evidence also suggests a relationship between dissociation during a traumatic event and the later development of PTSD. Researchers theorize that whereas peritraumatic dissociation might be adaptive during a traumatic event, subsequent use of this mechanism for coping with feelings of distress when reminded of the trauma might lead to survivors' failure to process adequately the trauma, including both its meaning and the emotions associated with the experience. Ultimately, this might result in the development of posttraumatic psychopathology.

For the most part, alterations in one's integrated memory and experience system are probably transient. However, we believe that the exposure of hospital mental health professionals, who are normally not a part of emergency response teams, to repeat mass disasters might put some of them at risk for the development of posttraumatic psychopathology. McCann and Pearlman (1990a) have argued that when traumatic memories are very significant to the mental health professional, insofar as they relate closely to personal needs and life experiences, and when the experiences of the traumatic event are not discussed, distressing traumatic memories can become lastingly integrated into the helper's memory system. The dissociation reported by our respondents, however, can also be seen as an ordinary adjustment attempt designed to help them carry on with their »normal« personal lives while living with the constant threat of terrorist attacks as a part of their daily existence.

In two studies collected from nonclinical Israeli samples during the same period some seemingly contradictory results emerged. For example: While 60 % of our randomly

sampled respondents felt their life was in danger and while 68 % felt their family or acquaintances were in danger, 82 % of the same sample felt optimistic about their personal future and 67 % felt optimistic about the future of the country. Here was a population that clearly appreciated the mortal risk they and their loved ones had been exposed to, yet they maintain self-confidence and an unwavering sense of hope about a better personal and collective future. In one of our studies we found that severe posttraumatic distress in the hardest hit areas was only 5.5 % (compared to 11.2 % of severe posttraumatic distress found in New York City in November 2001; Schlenger et al., 2002). We also found that although posttraumatic distress was higher in the hardest-hit areas, these targeted citizens enjoyed a better mood compared to what we measured in a remote southern city that was unaffected by war and terror (Somer et al., 2005).

Acceptance: A successful coping tactic

Our data suggest that Israelis used a variety of coping tactics, but the most frequently utilized were acceptance and social support. Acceptance was not only the most widely endorsed coping tactic but also an independent factor, a discrete form of coping, orthogonal to the statistical factors we named problem-solving coping (e. g., planning escape routes when sitting in a restaurant) and emotion-focused coping (e. g., exercising relaxation techniques) (Somer et al., 2007). Nothing helped. Problem solving coping, Emotion-focused coping, and Acceptance – were all positively correlated with a measure of posttraumatic distress. While posttraumatic distress was significantly, but not perfectly related to exposure, the general mood in Israel (we measured tension and sadness) was unrelated to actual exposure to terror attacks. All forms of coping except for acceptance, were positively associated with distress.

Acceptance seemed to be not only the most widely utilized way of coping but also the most helpful tactic. The Israeli population might have reacted with fatalistic acknowledgement of life under random and inescapable distress, and acceptance was actually associated with improved mood. Israelis were not merely dissociated or resigned to their fate, they responded with every way of coping possible: they planned were to sit in restaurants to maximize their survival, they avoided high-risk areas, they stayed in closer contact with their families, and they also accepted the uncontrollability of the situation.

In my opinion, this form of resignation has little to do with freezing or dissociation because it was accompanied by a wide range of active coping. Sadly, none of those ways of coping helped much during the Intifada, with the exception of Acceptance. Controllability awareness, the knowledge of what aspects of one's threatening environment are controllable and what are not, and the ability to apply the approach that is most appropriate to the condition, is strongly associated with psychological well being under the threat of terror (Somer et al., 2004b). It would seem that Israelis increase the intensity of their coping the more threatened they are. However, people had a less negative mood the more they were inclined to accept the terror campaign as unavoidable.

Overall, the Israeli public appeared to respond to the onslaught of painful random terror attacks by reacting with both appropriate distress and adaptive adjustment of their ways of life for brief periods of time, only rapidly to resume their normal routine and optimistic outlook on life shortly afterwards.

Let us examine more closely a few data sets on Israeli behaviour during the Intifada, to shed more light on the question: Was the Israeli nation displaying resilience under the threat of terror or was their reaction more a case of national dissociation? The Jaffe Center for Strategic studies at Tel Aviv University has been polling the Israeli public yearly since 1984 on various issues. Every poll has included the question: «Are you concerned that you or a member of your family could become victims of a terror attack?" The yearly average response to this question since 1993 shows a clear sense of fear immediately following major terror attacks and that this fear is responsive to fluctuations in the level of hostilities. The Jaffe Center's yearly survey of morale shows pattern reversal in responses concerning mood. During the first two years of the terror campaign more than half the Israelis reported bad or very bad mood, but during 2003-2004 more than ¾ of the respondents reported a pretty good or a good mood.

It would seem that bad mood + optimism + a general life satisfaction do not necessarily constitute a contradiction in Israel. Despite the negative mood reported by the civilians at the height of the violence, the figures on life satisfaction during the same period provided by the Israel Bureau of Statistics show quite stably, that most Israelis considered themselves happy with their lives during the bloodiest

years of the Intifada and more than a half of the population maintained a sense of optimism for a better future.

To assess the meaning of the acceptance coping under Type IV stress in Israel, I further sought to assess actual, objective measures of behaviours associated with well being. If acceptance had evolved as a form of dissociative pathology, such as in Acute Stress Disorder, I would have expected to see behavioural signs of anxiety by Israelis, such as: avoidance, anhedonia, depression or deterioration in indices of quality of life, as gauged by hotel occupancy data. The emerging picture reflects remarkable stability. Some seasonal fluctuations and sharp decreases in hotel occupancies are noted during the months of April 2002 and March 2003, when terrorist bloodshed peaked. 2004 was characterized by a reduction in the violence and a concomitant increase in the consumption of this leisure product and a gradual improvement in hotel occupancy over the years. Let us examine two additional impartial indices of well being.

A similar picture emerges when cinema attendance is examined: higher attendance during the summer holiday months, lower attendance during the winter and religious festivals, reflecting normal seasonal fluctuations. 2002 was a very bloody year and was also a low point in cinema attendance in Israel; April 2002, the most horrible month of the Intifada, marked by the Passover Eve massacre in Netanya, reflected a sharp decline in cinema attendance with 40 % fewer ticket purchases. But after 2002, and despite the continuing violence, cinema attendance is seen to pick up and to return to normal levels (Elran, 2006).

Discussion

Terrorism aims at breaking the spirit of, and at demoralizing a civilian population. The chronic traumatization Israelis have been subjected to at the start of the millennium created unique conditions of chronic stress, combined with opportunities for learning and adaptation. What have we learned about the effectiveness of terrorism from the Israeli experience?

A host of subjective and objective indices of morale and well being suggest that Israelis reacted with appropriate distress when exposed to random attacks on their civilian centres. Immediate reactions following major civilian loss of life included the expression of fears, sadness, and avoidance of public places. However, the Israeli society seems to have maintained an overall psychological stability throughout the terror campaign. Despite the Type IV stressor environment created by the attacks, subjective and object indices suggest that the society has not sustained enduring psychological damages. Shortly after most difficult periods, Israeli citizens seem to resume their normal routines. This ability of the public to bounce back to normality may suggest more national resilience than some form of national dissociation. Israelis tended to retreat to an apprehensive protective stance when attacked, only to discard it soon after the all-clear sounded.

Obviously, we have not measured all the possible effects of life under constant threat. While our data suggest that Israel is a resilient society, further research is needed to assess the impact of a century of persecution and war on more subtle indices such as empathy to the suffering of the «other", tolerance of the Arab minorities in Israel or, the role of power and force in interpersonal discourse among Israelis.

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