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# The Trauma of Terrorism: Strengthening Preparedness and Resilience

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On October 22, 2014 Cpl. Nathan Cirillo was gunned down at the National War Memorial in Ottawa before the sentry's killer raced to Parliament Hill and stormed the Centre Block. Armed with a rifle and a long knife, Michael Zehaf-Bibeau engaged in a shootout and was killed by Parliament security officers. Members of Parliament and others in the city spent hours locked down amidst chaos and uncertainty.

In a recent CBC News report by Brigitte Bureau, Parliament Hill security guards on duty that day discussed the trauma that still haunts them. Maurice Montpetit was locked down and unarmed with frightened MPs, unsure of what was outside the doors of the antechamber and lobbies in the House of Commons. At one point he heard over his radio that there could be as many as 13 gunmen on the building's roof. The next day, Montpetit said he returned to work "as if nothing had happened", however, the fallout from the attack was long-lasting. Montpetit's co-worker, Louis Létourneau, received the Star of Courage for his part in stopping the attacker's advance that October day, but his retirement was forced by post-traumatic stress disorder (PTSD) and vivid flashbacks still haunt him.

Létourneau and Montpetit are hardly alone. According to Bureau's report, "out of the approximately 30 House of Commons security guards on duty when the shooting occurred, at least 13 have suffered serious psychological problems. One has taken his own life." Roch Lapensée, president of the Union of Officers of the Parliamentary Protective Service, said that "The great majority of officers in the Parliamentary Precinct buildings on duty that day have suffered at different levels from the events." Psychological help was offered on the evening of the shooting to the small group of guards directly involved, but security personnel have criticized their employer for not doing a better job of watching for mental issues surfacing long afterward. Parliament Hill security reforms enacted after the attacks also left some guards from that day feeling like they did not receive moral support and respect.

## The Unavoidable Trauma of Terrorism[1]

Due to the nature of terrorism's purposeful and unpredictable violence, the psychological trauma terror attacks inflict is unavoidable. There is variability in the responses to trauma and the impact of terrorist attacks are not

limited to those directly affected by the violence. It is inevitable that direct and indirect victims of terrorism will have feelings of intense fear and be traumatized. However, the lasting effects of trauma can be softened and even prevented with pro-active and pre-emptive measures to reduce the risks of permanent traumatization of victims of terrorism. The stories of Létourneau and Montpetit, discussed six years after the attack, demonstrate that much more needs to be done in preventative and secondary actions to foster resilience to terror attacks.

Promoting preparedness and cultivating resilience play a significant role in diminishing the effects and probability of lasting traumatization by means of interventions that go beyond the bounds of psychotherapy. Prevention and intervention measures have to work collaboratively with proper access to mental healthcare, early identification of risk factors, integrated medical screening, and education and intervention efforts aimed at public safety and healthcare professionals. If mental health disaster planning and preparedness can be built into permanent infrastructures, effective response capability will endure in an emergency.[2]

## Supporting First Responders

Security personnel, law enforcement officers, ambulance personnel, firefighters and fire personnel, and other emergency-response workers are often the first to respond to terrorist attacks that are distressing and horrific by design of the perpetrators. There is an important body of psychological research on the effects of trauma on front line officers and it suggests that there are major negative consequences of unresolved trauma that negatively affect both physical and mental health.[3]

Part of the day-to-day duties of first responders is attending to critical incidents. Traumatic incidents accumulated throughout a career are, as a whole, intertwined and unified, shaping the complex form of trauma. Therefore direct or indirect exposure to trauma is not the only factor that may lead to a later experience of trauma.[4] One challenge is the idea that trauma happens to others and "not me" and that first responders are supposed to protect and take care of victims, rather than becoming victims themselves, which goes against their sense of identity.[5] In order to support, educate, and help first responders, the academic literature on trauma and terrorism highlights the following interventions to prevent and/or cushion the effects of psychological stress and promote resilience:[6]

- ***Police culture:*** Police educators are in a unique position to address the issue of "police culture" and senior officers who carry out the training are in a unique position to help the next generation of officers to be cognizant of the ways to handle exposure to trauma and loss.[7] They can encourage police officers to see themselves as possible victims and/or survivors of terrorism and can work to create bridges with mental health professionals. This comes in the form of resilience promotion programs (which have been successfully applied to US army military personnel).[8] Such programs should not only be instituted and promoted to assist rookie officers and personnel, but senior first responders serve to benefit as well. Breaking the stigma associated with reaching out for help (which is often paired with unsought negative changes in job duties or reduced pay) is essential to providing support for first responders.[9]

- ***Journaling:*** Training modules with proven success have helped police officers improve their well-being and stress resilience through relaxation techniques and visual imagery exercises.[10] Practical exercises in

training include: psycho-education about trauma, mindfulness/awareness training called "be where your feet are", and journaling. Police trainee participants in one study reported that they were more comfortable writing than talking; writing in journals also helped participants organize their memories.[11] There is also a desire to link mindfulness/awareness with procedures in the field, based on the ability to "check the reality of where you are and who you are", which often prevents negative effects frequently experienced in the aftermath of trauma, like disassociation.[12]

- ***Peer-counselling:*** Organizations (those who hire, train, support, and oversee) first responders should develop necessary interventions to provide responders with appropriate tools and coping mechanisms for their complex and cumulative form of trauma. As one study on police officers noted, "Thereby, police organizations would become a type of protective milieu that apply such programs and train their personnel so that police officers would be more resilient in dealing with the exposure to different threatening situations."[13] Studies have found peer-counselling effective; those providing the support ought to be directed by guidelines from mental health professionals.[14]

- ***Practice-based treatment:*** Continued and new conversations among mental health professionals and first responder organizations. This would help "the development of a practice-based multifaceted treatment that would enable mental health professionals to respond to police officers' and their families' needs more effectively, considering the multitude forms of police trauma and its consequences in the police organizations."[15] Clinicians will then be able to view police trauma as a cumulative product, formed by critical incidents and multiple factors rather than a single traumatic event that triggered symptoms.[16] Job-related PTSD can be further complicated by a child abuse history and significant dissociation or mood dysregulation.[17]

- ***Treating PTSD:*** In terms of treatment to mitigate the lasting effects of trauma, one example of PTSD treatment in first responders is in the form of a four-phase approach used in the McLean Hospital LEADER program: Phase 1: Diagnostic assessment; Phase 2: Symptom stabilization and skills training; Phase 3: Trauma-focused processing; Phase 4: Consolidation and aftercare.[18] Another study also describes an integrative approach for the treatment of PTSD in 9/11 first responders that is built around three core techniques: 1) Meaning making: engaging the patient in meaning making regarding the traumatic experience; 2) Following the affect: bringing about a situation where the patient spends sustained periods of time focusing on the source of the distress; 3) Interpreting defences: interventions that address avoidance strategies.[19] In addition, studies have explored the merits of Cognitive-Behavioral Therapy (CBT) for treatment of PTSD in first responders.[20]

- ***Female First Responders:*** Research also draws attention to special considerations for female first responders. One study cautions that numerous factors need to be kept in mind for the treatment of female first responders, "including their potentially different attachment styles from male first responders and also the likelihood of their having relational versus individualistic coping styles."[21] According to one study, "Successful treatment is best achieved through person-centered care and careful attunement to both the stated and inferred individual goals of the patient."[22] It can be assumed that

multiple factors are also at play for the treatment of LGBTQ, minorities, and others with diverse experiences and backgrounds.

- ***Family support:*** Research indicates that there is a "buffering" effect of social support on risk for PTSD. It underscores the importance of preventative efforts to increase family and work social support during disaster response and recovery. Such support may help mitigate the harmful effect of trauma, as well as other risk factors, and promote resilience.[23] The support of spouses, family, religion and/or faith, a sense of community support for first responders, and a prepared team of mental health professionals ought to work together to buffer the risks.[24]

- ***Pre-incident training:*** Those who administer first responder programs should recognize the resilience of first responders while also acknowledging the importance of emotional and psychological support sources for building and maintaining that resilience.[25] Efforts should be made to reinforce and strengthen such sources before a terrorist incident occurs, including family programs in departments, recognition of the role religion and/or faith plays – perhaps through a volunteer or official chaplain's office, and mental health professionals gaining the trust of first responders before an incident to strengthen support during and after.[26]

## Conclusion

More must be done to protect our first responders before and after traumatic attacks. Terrorism involves random victimization and the arbitrary nature of this blind violence affects the psychological and mental health of direct and indirect victims. The effects of the trauma can be widespread and long-lasting, which determines how individuals, families, communities, and nations cope. We must prioritize strengthening the resilience and preparedness of potential victims and the employment, social, and healthcare constructs within which they operate. First responders have the unique positions of dealing with horrific events at one moment then needing to calm, console, and take charge, and while emotional responses are inherent in these responders, ignoring them comes at a high price of reduced quality of life and well-being.[27] There must be an emphasis on building mental health planning and preparedness into permanent infrastructures to promote effective response capability. This offers a hopeful avenue into a future where support is integrated, and terrorism terrorizes less.

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[1] This work is derived from Dr. Nash's forthcoming chapter "Prevention of Lasting Traumatization in Direct and Indirect Victims of Terrorism" in the *Handbook of Terrorism Prevention and Preparedness* (ed. Alex P. Schmid). Dr. Nash is also working on how we define "terrorism" in the wake of attacks and this work on trauma and terrorism is not exclusive to the "terrorism" activity label as defined by the Canadian Criminal Code.

[2] Sederer, Lloyd I. et al., 'Challenges of Urban Mental Health Disaster Planning'; in: *The Trauma of Terrorism: Sharing Knowledge and Shared Care: An International Handbook*, (Ed.) Yael Danieli, Danny Brom, and Joe Sills, (New York: The Haworth Press, 2005), p.704.
[3] Ibid, p.105.
[4] Papazoglou, Konstantinos, 'Conceptualizing Police Complex Spiral Trauma and its Applications in the Police Field', *Traumatology,* 19(3), 2013, p.198 and p.205.
[5] Manzella, Christiane and Konstantinos Papazoglou, 'Training Police Trainees About Ways to Manage Trauma and Loss', *International Journal of Mental Health Promotion*, Vol.16, No.2, 2014, p.105.
[6] Operationalizing the prevention and preparedness suggestions should be designed to fit the specific needs to the culture, place, and type of trauma. They should also be tested, refined, and re-evaluated.
[7] Manzella, Christiane and Konstantinos Papazoglou, p.106.
[8] Ibid.
[9] Haugen, Peter T., Mark Evces, and Daniel S. Weiss, 'Treating Posttraumatic Stress Disorder in First Responders: A Systematic Review', *Clinical Psychology Review*, 32(5), 2012, p.376.
[10] Manzella, Christiane and Konstantinos Papazoglou, p.106.
[11] Ibid., p.111.
[12] Ibid.
[13] Papazoglou, 2013, p.205.
[14] Ibid.
[15] Ibid.
[16] Ibid., p.206.
[17] Lewis-Schroeder, Nina F. et al., 'Conceptualization, Assessment, and Treatment of Traumatic Stress in First Responders: A Review of Critical Issues', *Harvard Review of Psychiatry,* 26(4), July-August 2018; URL: www-ncbi-nlm-nih-gov, p.6 [of 7], [WC: 216-227].
[18] Ibid.
[19] Haugen, Peter T. et al., 'Integrative Approach for the Treatment of Posttraumatic Stress Disorder in 9/11 First Responders: Three Core Techniques', *Psychotherapy*, Vol.50, No.3, 2013, p.338.
[20] Papazoglou, Konstantinos, 'Examining the Psychophysiological Efficacy of CBT Treatment for First Responders Diagnosed With PTSD: An Understudied Topic', *Journal of Police Emergency Response*, 7(3), July-September 2017, pp.1-15; and Koucky, Ellen M., Benjamin D. Dickstein, and Kathleen M. Chard, 'Cognitive Behavioral Treatments for Posttraumatic Stress Disorder: Empirical Foundation and New Directions', *CNS Spectrums*, 18(2), April 2013, pp.73-81.
[21] Lewis-Schroeder, Nina F. et al., p.12.
[22] Ibid.
[23] Pietrzak, R.H. et al., 'Trajectories of PTSD Risk and Resilience in World Trade Center Responders: An 8-Year Prospective Cohort Study', *Psychological Medicine*, 44(1), January 2014, p.216.
[24] Schorr, John K. and Angela S. Boudreaux, 'Responding to Terrorism in the USA: Firefighters Share Experiences in Their Own Words'; in: *The Trauma of Terrorism: Sharing Knowledge and Shared Care: An International Handbook*, (Ed.) Yael Danieli, Danny Brom, and Joe Sills, (New York: The Haworth Press, 2005), p.588.
[25] Ibid.
[26] Ibid.
[27] Manzella, Christiane and Konstantinos Papazoglou, op. cit., p.104.