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Abstract. This article describes implicit assumptions, and clinical and political implications, of prescriptions for psychological services in the aftermath of terrorism-created disaster. The article is one of a series in IBPP that focuses on crisis psychology, stress management, and critical incident debriefing in an era of a United States Government (USG)-announced war on terrorism with global reach.

Disaster strikes. And the disaster has been effected through terrorism. One immediate reaction to such disaster in the United States (US) is to activate, deploy, and employ psychological assets and services to prevent, attenuate, and manage noxious intrapsychic and behavioral consequences of people who are conceived as potential or actual victims.

There are (or should be) two main objectives for such psychological services, i.e., two sorts of noxiousness that are targets of intervention. The first comprises elements of clinical functioning and of assumed best practices of living a life. The second comprises elements of political functioning and assumed best practices of living a life. The similarities and differences between the assumed best practices of living a life in the clinical and political realms are at Issue in this article.

Often enough, anything that feels bad to an individual is deemed a target of intervention in the clinical realm. Psychological phenomena that are common examples of feeling bad include anxiety; depression; anger; apathy; overall emotional contamination of cognition; a seeming blockage of emotion so that cognition is experienced by the self and interpreted by others as emotionless; cognition that seems to be too rigid, too labile, too slow, too quick, or too consensually inappropriate as to content and associations; and behavior that seems less instrumentally successful than usual for specific individuals.

There are problems with the whole conceptual enterprise pursued throughout the clinical realm by psychological experts, themselves often labeled as therapists, caregivers, and grief and stress experts. The first is the frequent medicalization of intrapsychic and behavioral phenomena as symptoms of a disease or, in the context of disease being a Holy Writ of the medical profession, of the more secular construct of dysfunction or disorder. As both the scared and the secular sources and their expressions are reflections of consensual language usage with no necessary ontological status, the premise of the need for intervention and the conclusion of another premise for the end of intervention are at least questionable. In essence, linguistic elements of a narrative are the target of intervention and dictate the motive for and endpoint of intervention.

Related to medicalization is a second problem that may be labeled as not beyond the pleasure principle. Here, anything but intrapsychic and behavioral phenomena that feel good or are deemed efficient and effective in instrumental striving becomes the target of intervention. In general, a weltanschauung is constructed and promulgated that the supposed to be of living is an escape from freedom of heterogeneous psychological possibilities and an avoidance of the existential possibilities of living with one what desires and desires not. Lotus land is the presumed standard and desired endpoint of psychological service and a constant reminder that one is not what one should be - premises that if bought into by consumers contributes to the material benefits of psychological service providers. This

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perspective both exemplifies a hubris inviting a horrific deus ex machina or, presumably, the staying hand of hilarity experienced by the Gods.

Again, related to medicalization, is a third problem that involves the ripping out of elements from a narrative flow. In other words, the anxiety, depression, or other therapeutic targets are treated in isolation from their context. To treat a target out of context is to necessarily render the target and the treating itself as meaningless. In essence, one destroys that target, because it only can have substance through its interrelationship with all else it touches and changes into something else once this interrelationship is in any way changed. Yet, objectifying a target and then to target it often is presumed to be a benign and even necessary approach to mental health. The typical narrative for this ripping from narrative may be as follows.

[The anxiety is the not me, not the me. Because the anxiety is the not me and should be and is the target of intervention, the not me is bad, and the me is good. Therefore, the me is not the target of intervention only the not me. The not me can then be targeted by any means necessary for destruction. The not me as Alien Other will be destroyed. I will remain whole.]

The above narrative as narrative destructor presents a cured self that actually is a more constrained self with much more limited degrees of freedom.

Finally, a fourth problem in the clinical realm also segues into the political realm as it addresses political power. Psychological services presume an inferior-superior status between those seeking help and those providing it. The services also presume less than complete self-ownership of one's psychology and, thus, less responsibility for one's actions. So, too, the services become a commodity zealously protected by the service provider as a member of a notional, virtual, or socially validated guild. The so-called art and science serving as the foundation for services can, then, only be maintained and further developed with an eye on the consequences for political power of service providers.

In the political realm of terrorism-effected disaster, the crucial Issue is how the psychology of the clinical realm relates to the terrorists' political goals. In this respect, the clinical most often supports terrorism politics. For example, terrorists are presumed to have the power to create the sacred or secular aspects of disease and disorder. Terrorists are presumed to have a more politically powerful self-narrative that justifies and privileges the giving out of pain even as terrorist targets must give up pain as the Alien Other or accept pain as the bad me. And clinical prescriptions often make the terrorists' point of the material and spiritual decadence or impurity of individuals who are targeted.

To this last point, just one example involves a clinical professor of psychiatry at a US medical school who prescribes vacations, theater parties, follow-up therapy visits, safety, and privacy, all almost unknown and unavailable to the wretched of the earth.

The clinical and political aspects of psychology services in the aftermath of a terrorism-effected disaster are guaranteed to achieve three consequences. These are to further the material goals of psychology providers, the political goals of terrorists, and the enmeshment of the victims of psychology and terror. (See Long, F.Y. (2001). Psychological support in civil emergencies: The National Emergency Behavior Management System of Singapore. International Review of Psychiatry, 13, 209-214; Norris, F. H., Perilla, J. L., Riad, J. K., Kaniasty, K., & Lavizzo, E. A. (1999). Stability and change in stress, resources, and psychological distress following natural disaster: Findings from Hurricane Andrew. Anxiety, Stress & Coping: An International Journal, 12, 363-396; Stein, H.F. (2002). Toward an applied anthropology of

disaster: Learning from disasters--experience, method, and theory. Illness, Crisis & Loss, 10, 154-163; Turner, A.L. (2000). Group treatment of trauma survivors following a fatal bus accident: Integrating theory and practice. Group Dynamics, 4, 139-149; Webb, T.E. (1999). Staying the course in stormy seas: Establishing a central critical incident stress management team in the Navy Marine Corps environment. International Journal of Emergency Mental Health, 1, 43-50.) (Keywords: Psychology, Terrorism.)