This report is the 2nd Edition of the White Paper Managing the Psychology of Fear and Terror: Strategies for Governments, Service Providers and Individuals. This White Paper was the outcome of the First International Assembly on Managing the Psychology of Fear and Terror (Assembly) convened by Issues Deliberation Australia / America in Austin, Texas in 2004. One of the recommendations from that Assembly was an international organisation dedicated to assisting in the psychosocial recovery of communities who have suffered the affects of terror, armed conflict or natural disasters. The result was the establishment of Psychologists, Psychiatrists and Social Workers Without Borders, now known as Psychology Beyond Borders (PBB). PBB is committed to informed policy, research, education, and psychosocial service delivery in the prevention, preparedness and response to terror attacks, armed conflict or natural disaster.

Psychology Beyond Borders, in partnership with its extensive network of leading experts, is currently working on expanding the ideas presented in the Assembly White Paper while including the latest research on strategies to manage the psychology of fear terror. This document is an overview of the major themes and recommendations that were originally presented during the Assembly.
ON AUGUST 19, 20 AND 21, 2004, 90 LEADING psychiatrists, psychologists, social workers, therapists, and academic experts on fear, terror, and trauma from around the world came together in Austin, Texas for the first “International Assembly on Managing the Psychology of Fear and Terror™.” The Assembly was convened by Issues Deliberation America / Australia, in collaboration with the University of Texas and the University of South Australia.

The goal of the International Assembly on Managing the Psychology of Fear and Terror was to initiate international dialogue among the world’s leading experts in the field so they could join together to develop strategies for combating international, national, and local fear and terror. The Assembly involved two and a half days of collective and collaborative problem-solving in small group and large plenary discussion sessions, led by trained facilitators.

The Assembly was not intended to be a political event; rather it was an international collaborative problem-solving venture for the benefit of people everywhere—regardless of nationality, religion, or politics—who find themselves paralysed by fear. An international Board of Patrons endorsed the Assembly, including former Australian Prime Minister Bob Hawke, former British Prime Minister John Major, former Israeli Prime Minister Shimon Peres, and Nobel Peace Prize Winner Archbishop Desmond Tutu. An Advisory Board, with members from the Departments of Psychology, Sociology, Government and Public Affairs from the University of Texas and the Hawke Research Institute at the University of South Australia provided advice on delegates to be invited and the agenda.

Prior to the Assembly, invited delegates were asked to submit a summary of their recommended strategies for managing the psychology of fear and terror. They were then invited to do the same at the completion of the Assembly. Thus, the strategies described in this White Paper are the result of a comprehensive review of the extant research prior to the Assembly, individual written submissions (pre- and post-Assembly), small group discussions, and all-of-delegate plenary sessions during the Assembly.
COMMENTS BY WORLD LEADERS

I would be honoured to join the International Board of Patrons of the International Assembly on Managing the Psychology of Fear and Terror.

JOHN MAJOR (15/04/04)

The issue you describe is a real and challenging one, as terrorism seeps into the everyday consciousness of people around the globe. I hope the International Assembly will stimulate some useful thinking on this and help find solutions to address the fear of terrorism.

KOFI ANNAN (18/5/04)

The issue being addressed is indeed one that is increasingly pertinent across the world, hence the importance of the project.

SHIMON PERES (16/6/04)

[I] am delighted that the Assembly was such a success. I commend you on a job well done.

REVEREND DESMOND TUTU (9/9/04)

Painting by an Israeli teenager to depict his interpretation of “peace”
The Ort School, Israel
THE PHYSIOLOGY OF FEAR

PHYSICAL RESPONSE TO FEAR

THE DETECTION AND RESPONSE TO FEAR by the human body has been studied extensively. The human response to danger is both innate and learned: when the cognitive system detects stimuli identified as danger through instinct or experience, a flood of responses is activated by the amygdala. The well-documented fight-or-flight response involves the redistribution of blood away from the skin and gut and toward the brain and muscles so as to provide energy, and is coupled with a variety of behavioural and physiological outcomes such as freezing, changes in blood pressure and heart rate, and the release of a number of hormones. These natural human responses to fear and danger have powerful influences over cognitive processing. Such responses to fear can affect attention, perception, memory, and decision-making to varying degrees, depending upon the intensity, duration, and nature of the threat, as well as the individual’s resilience in the face of the threat (e.g. LeDoux, 2002).

LIVING UNDER SUSTAINED FEAR

Since September 11, 2001, citizens around the world have lived at elevated levels of fear. A recent study by Silver (2004) has shown that Americans have sustained mid-range levels of fear since October 2001, despite varying official levels of alert. This heightened level of fear—not necessarily correlated with the real risk of an attack—was revealed by respondents’ answers to questions (on a scale of one to five) about how
often they have had fears of a terror attack in the last week (Q1) or if they worry that an act of terror will personally affect them (Q2). These sustained levels of fear are shown in Figure 1. Furthermore, several national studies in the U.S.A. following the September 2001 attacks reveal the multiple negative mental health effects—not only in those residents directly exposed to the terror attack, but also in those indirectly exposed via disturbing media images (Butler, Garlan & Spiegel, 2004; Galea et al., 2002; Marshall 2004). Indeed, the symptoms of individuals who were indirectly exposed to the attacks via the media can be as intense as those directly exposed. Prolonged, repetitive exposure to the horrific images of terror may indeed contribute to ongoing heightened levels of post-traumatic stress and related mental health problems in the wider society well after the actual attack (Silver, 2004).

Some societies appear to cope better than others in living with fear and terror. Research in Israel examining stress-related mental health symptoms and coping behaviours suggests that this society, under regular ongoing terrorist attacks, may fare better than other societies on traditional measures of post-traumatic stress. For example, one study found that while Israelis exposed to terrorism showed more distress and lower perceptions of safety than those not exposed, they did not display high levels of PTSD symptoms. The researchers therefore concluded that “considering the nature and length of the Israeli traumatic experience, the psychological impact may be considered moderate” (Bleich, Gelkopf & Solomon, 2003). Israelis, Palestinians, and other nationals in high terror incidence areas are able to maintain an existential acceptance of a certain level of violence, and thus go about their daily lives with minimal disruption—for example, buses back on their routes, planes back in the air, and schools back in business—in relatively short time frames (Berger, 2004). Other studies reveal that living under sustained fear and stress, while not necessarily resulting in widespread post-traumatic stress disorder or other diagnosed mental illness, may nevertheless have long-term detrimental psychological and physical impacts (Berger, 2004). These are explored in detail in the next section.

Given the significant impact of prolonged exposure to fear on the human mind and body, we should, as a society, be extremely wary of the actions and rhetoric of political leaders and media representatives who consciously contribute to sustained levels of fear, unrelated to the actual risk of attack. Equally important, significant long-term psychological and physical ramifications can be reduced by the adoption of a systematic, comprehensive coordinated approach to build societal resilience. Such an approach must be planned and enacted in detail prior to large scale disaster to ensure the best possible response during and after the event. Communication of such preparedness can allay fear and terror.
MANAGING THE PSYCHOLOGY OF FEAR AND TERROR

EXPERIENCING TERROR IS A PARADOX

DISCUSSIONS THROUGHOUT THE ASSEMBLY revealed the following major themes: Communities and individuals are “resilient” and adaptable following a terror attack or massive disaster. Communities and individuals not only tend to cope, but they also grow in both strength and character. While hope can and does arise from trauma, experiencing terror is a horrific way to grow. Experiencing a terror attack causes tragic, grievous loss. However, such tragedy can also yield opportunities for life-affirming change.

COMMUNITY RESILIENCE AND ADAPTABILITY MANIFEST IN MULTIPLE WAYS.

Direct or indirect experience of terror can lead to:

- COMMUNAL AND INDIVIDUAL STRENGTH OR “LIFE DEFINING GROWTH” (Tedeschi & Calhoun, 1995).
- COMMUNAL CONNECTEDNESS.
- RENEWED FOCUS ON LESS MATERIAL ASPECTS OF LIFE, AND MORE FOCUS ON THE RELATIONAL ASPECTS OF LIFE.
- INCREASED ALTRUISTIC BEHAVIOR-GIVING TO OTHERS.
- MITIGATION OF THE “Bystander Effect.”

COMMUNITIES AND INDIVIDUALS SUFFER IMMEASURABLY. PROLONGED EXPOSURE TO FEAR AND TERROR CAN HAVE SIGNIFICANT IMPACTS ON THE MIND AND BODY.

The well-documented consequences for survivors of a terrorist attack are posttraumatic stress disorder (PTSD), depression, and functional impairment. Other symptoms might not be so obvious. The less-documented effects of exposure to fear and terror include:

- IMPAIRMENT OF THE IMMUNE SYSTEM.
- NON-CLINICAL DEPRESSION AND ANXIETY.
- DETRIMENTAL CHANGES IN EATING PATTERNS, AND SUBSEQUENT HEALTH EFFECTS LIKE STOMACH PAIN, INTESTINAL PROBLEMS, TOO LITTLE OR TOO MUCH SLEEP, ONGOING FATIGUE.
- INCREASED LEVELS OF RISK-SEEKING BEHAVIOUR.
Research in Israel has revealed population-level behaviour changes following a terror attack. For example, a study by Stecklov and Goldstein (2004) found a decrease in light automobile accidents the day after an attack, followed by a spike in traffic accident fatalities three days after an attack. The effects on accidents are proportional to the severity of the attack. The researchers explain that the phenomenon is caused by heightened levels of stress. Trauma counsellors suggest that humans can become addicted to alertness and to heightened adrenalin levels, and so seek other ways to maintain that level of alertness (Berger, 2004; Pfefferbaum, North, Flynn, Norris, & DeMartino, 2002). This is particularly apparent in adolescents. Examples of increased sensation-seeking behaviours to maintain the alertness include hitchhiking, dangerous driving, and increased alcohol consumption.

- NEGATIVE CHANGES IN MORALITY.
- CHANGES IN SELF-IDENTITY.
  Survivors may blame themselves or take on the persona of “the victim.”
- CHANGES IN COGNITIVE SCRIPTS.
  Previous cause-and-effect links in the survivor’s cognitive map (or mental conceptualization of the world) are broken and new variables may be added (Shalev, 2006). The world becomes exaggeratedly unpredictable, uncontrollable, dangerous, and unjust. Children may develop a sense of betrayal by adults who are meant to protect them.
- FEELINGS OF SURVIVOR GUILT.
  Surviving an attack in which others were killed can have an extremely paralysing and isolating impact on the survivor’s daily life (Ursano, Fullerton, & McCaughey, 1994).
- SECONDARY TRAUMA OF EMERGENCY WORKERS CAN RESULT IN SEVERELY DEBILITATING SYMPTOMS FOR YEARS FOLLOWING EXPOSURE TO TERROR.
  People caring for survivors, even those not exposed directly to the traumatic event, can develop significant psychological problems due to their experiences (Marmar et al., 1999).
- SEVERE TRAUMA TO THOSE VICARIOUSLY EXPOSED TO TERROR.
  Many people became traumatized through witnessing the horror on television and on the internet. Symptoms of vicarious exposure can be as severe as those of direct exposure (Silver, 2004; Schuster et al., 2001).
- INABILITY TO VISUALIZE A FUTURE.
  This can even translate into aspirations to become a suicide bomber. One study in the Middle East showed that 25 percent of adolescents wanted to be a martyr, although only a very small percentage realize those aspirations (Zaqout, 2004).
MAJOR STRATEGIES FOR MANAGING THE PSYCHOLOGY OF FEAR AND TERROR

THE FOLLOWING SET of strategies for managing the psychology of fear and terror is meant to be a “menu” from which trauma treatment agencies can draw, depending on their unique context. Strategies range from the global to the local.

I. FACILITATE INFORMED PUBLIC DIALOGUE ON TERROR

Facilitate understanding of terrorism and terrorists through informed public dialogue about the nature of terrorism, terrorists’ goals and methods, statistical probabilities of the likelihood of any one citizen being the victim of terror, and preparedness for an attack.

A. BREAK DOWN THE GENERALIZED FEAR OF TERROR WITH PUBLIC EDUCATION ABOUT TERRORISTS’ GOALS / METHODS.

Academic, government, non-government, and media organizations can facilitate objective, non-partisan, non-sensationalized education about why terrorists are so driven to do what they do. Examples of ways this can be achieved include questioning conditions or policies that leave these groups seeing few choices but to inflict horror; facilitating informed debate about what can be done about those policies and conditions that may have contributed to the terrorism; and, importantly, encouraging vigorous public debate about alternative ways to deal with terrorism other than through military force.

B. EQUIP INSTITUTIONAL AND POLITICAL LEADERS TO CONTRIBUTE TO COPING, AND RESILIENCE STRATEGIES RATHER THAN EXACERBATING FEAR AND TERROR.

Political leaders must be educated on how they contribute to “pre-trauma” and “post-trauma” stress of citizens with their use of vivid, horror-inducing words and images and exaggerated threats. Political leaders can, instead, mitigate citizens’ fear and stress by providing comforting assurances about the real likelihood of an attack, by informing the public about the least likely geographic targets of an attack, as well as assurances by the governments and agencies of their preparedness should there be an attack (assuming governments and agencies are prepared at all levels).

When an act of terrorism begins and state leaders must respond, they do have choices. They can define the surprise act causing death and devastation as a crime and move heaven and earth by deploying the police forces, launching covert operations of state, and invoking the mechanisms and treaty powers of international law to bring the criminals to justice. Or, they can define the surprise act as an attack on the country and declare: “We are at war!” The first choice criminalizes the act and focuses attention; the second militarizes the issue and sets in chain a series of expanding activities that escalate fear.

DR J. PATRICK BOYER, Q.C, Adjunct Professor, Department of Political Science, University of Guelph, Ontario, Canada, National Press Club Media Briefing on International Assembly on Managing the Psychology of Fear and Terror, September 10, 2004.
C. HELP THE MEDIA UNDERSTAND THEIR ROLE IN CONTRIBUTING TO OR MITIGATING FEAR.

As noted earlier, the level of worry reported by Americans in the years since September 11, 2001 has remained elevated. Although there was a decline after the first one or two months following 9/11, national levels of fear in the U.S.A. have been relatively unchanged, despite increases and decreases in government alerts since that time (Silver, 2004; Schuster et al., 2001). In any society, the principal conveyor of terror is the media. Interestingly, the level of terror-related television exposure following the September 11 attack was highly correlated with later stress symptoms (Silver, 2004). The more television watched, the higher the likelihood of later development of post-traumatic stress. Constant use of embellishing or sensationalizing words and the repeated use of violent images—for example, bloody bodies and scenes of the World Trade Center collapsing—especially during children’s television viewing times, can both traumatize and re-traumatize members of the general public and the survivors. Specific suggestions for the media appear later in this paper.

D. EDUCATE CITIZENS ABOUT THE REAL RISKS OF TERROR.

The probability of any one citizen being a direct victim of a terror attack is very low compared to other causes of death or injury. For example, American citizens should be more fearful of dying from a heart attack or a car accident than a terror attack (see Figure 2) (Marshall, 2004). According to Barry Glassner (1999), disseminators of information—for example, journalists and television newsmagazine producers—routinely allow emotional accounts to trump objective facts. Glassner argues that the sacrifice of the factual for the sensational and emotional is fear mongering at its most sinister.

> Within public discourse, fears proliferate through a process of exchange. It is from the cross current of scares and counter-scares that the culture of fear swells even larger.

Barry Glassner (1999)

Individual citizens can reduce their fear by examining the facts - in most countries, the statistical likelihood of any one citizen being killed or injured in a terrorist attack is virtually zero.
E. EDUCATE CITIZENS ABOUT LOCAL, STATE, AND NATIONAL GOVERNMENTS’ PREPAREDNESS PLANS.

National, state, and city governments should have pre-determined crisis response plans, including delineation of who will do what when. Local community groups and corporations should be included in developing and implementing the plan. This assures citizens that all that can be done in preparation is being done. Sharing preparedness plans can occur through media, schools, churches, and community groups, and through speeches of government and community leaders.
F. **Inform Citizens of Best-Practice Responses to Terror Attacks.**

Information about best practice responses – from the national to the individual levels of response - should be readily available at the local government level, with all involved aware of the crucial positive role that engaged community support can play. Following a crisis, community groups and individual citizens should have prototypical plans on how to enact best practice responses. At the local community level, this could include calling a pre-determined list of resources - friends, family, professionals, or consulting pre-specified Web sites to quickly mobilize needed support.

G. **Facilitate Informed Public Dialogue and Practice on Tolerance and Cross-Cultural Understanding.**

Fear of terror attacks can exacerbate and be exacerbated by cross-cultural tensions and intergroup prejudice. It is easy to respond to terror attacks by demonizing groups associated with the perpetrators, but such demonization contributes to intergroup tensions that in turn contribute to distress and increase the likelihood of negative events. This can be mitigated by programs designed to increase intergroup tolerance and cross-cultural understanding. For example, in New York after 9/11, mental health responders experienced some hostilities especially in areas with predisaster problems. These were overcome by involving community members in problem solving (Norris & Alegria, 2006). Many interfaith groups are now operating joint programs across America and other western democracies. More of this cross-cultural dialogue and interaction should be encouraged and enacted. Schools can also include factual information about more controversial cultures in their curriculums.

H. **Facilitate Informed Public Dialogue on Alternatives to Fear, Terror and “War”.**

Societies, governments, and individuals face a choice in how they will respond to terror attacks. Alternative responses to terror attacks beyond “war” must be explored and executed. For example, Canada’s response 40 years ago to escalating terrorist acts by the Front de Liberation du Quebec (FLQ), included the invocation of the War Measures Act. All civil liberties were suspended. Tanks occupied the streets of Montreal, soldiers in Ottawa patrolled parliament, and 450 people were arrested overnight without warrant, with many held as “suspected” FLQ members. This reaction was highly controversial, and protests and a vigorous national debate during this “October Crisis” resulted in a reframing of the previous terrorist acts from acts of war to criminal acts. That is, the violent acts of the terrorists were not treated as new-order political crimes, but as straight-line crimes under the existing criminal code. When the separatists were captured and brought to trial, they were not charged with “political assassination” as they had hoped, but for murder. FLQ leaders were imprisoned or exiled and seen as
murderers not martyrs. The FLQ ceased activity by 1971 (Boyer, 2004). A similar “crime” focus was evident following the terror attacks in London during July 2005.

2. BUILD SOCIETAL RESILIENCE THROUGH A SYSTEMIC NATIONAL APPROACH

Facilitate understanding of how governments, service providers, and individuals can respond to fear and terror by building a systemic national, communal, and collaborative approach to improve societal resilience. A resilient society is a prepared society (e.g. Ursano, Fullerton, & McCaughey, 1994).

In countries whose citizens live with terror as a daily reality and who have been under sustained threat for years, experience suggests that a whole-of-society/all-of-infrastructure preparedness must be planned. For a resilient, prepared society, nations, states and cities must integrate their prevention strategies, treatment strategies (curative interventions), and community services strategies (community interventions).

Of crucial importance is long-term planning and advanced interagency collaboration. Pre-planning is essential to enable best practice implementation following an attack. If detailed planning is not done in advance, panic and chaos will dominate.

2.1 BUILDING SOCIETAL RESILIENCE THROUGH PREPAREDNESS

In order to prevent maximum trauma and terror from any one terror attack (therefore to minimize trauma), nations must build the coping capacity of communities at all levels of society. A society’s natural strengths should be built upon so that communities can support themselves in crisis (and reach out to others in greater stress) (Butler, Panzer, & Goldfrank, 2003). “Capacity building” happens before and after a challenge so that communities can effectively and quickly engineer new coping networks and consolidate existing ones. In order to become more “resilient,” a society must be able to cope with whatever happens. The following measures can be enacted to enhance societal resilience in anticipation of a terror attack.

A. HELP LOCAL GOVERNMENTS TO PLAN FOR DISASTER PREPAREDNESS.

Increase intercity collaboration and share experiences from well-prepared cities, including their ability to locate all social services in one location immediately following an attack. For example, New York and New Jersey both set up “Family Assistance Centers” that provided a central location collecting all the resources available for people affected by the attacks. Federal, state and local governments should facilitate advanced training of local government personnel in best practice crisis responses, including both the physical and the psychological. Well-prepared cities should share their best practice with less well-prepared. Examples abounded during Hurricane Katrina in 2005. For example, when Texas accepted over 250,000 evacuees, Houston and Austin adapted more effectively than other cities. Post-disaster operational debriefing by all involved can report how the response should be improved further.
B. EQUIP SCHOOLS FOR DISASTER PREPAREDNESS.
School-based approaches have proved effective following other disasters. School-based screening for stress responses provides the most inclusive model for a non-stigmatizing, non-biased, normative environment for identifying the most affected children and adolescents (e.g. Pat-Horenczyk, 2004a). This is particularly important where media exposure may have traumatized children a long way from the actual disaster area. The Israeli experience suggests that any comprehensive school-based program should include intervention at all levels of the school system. Programs should be designed to meet both the different developmental and individual needs at each school. Dr Ruth Pat-Horenczyk of the Israel Center for Treatment of Psycho Trauma says this means building resilience in the classroom—for example:

- crisis-coping workshops for all school staff, particularly teachers
- crisis-coping workshops for parents
- screening followed by tailored treatment for PTSD and functional impairment
- stress management programs for all in the school community

C. ESTABLISH INTER-RELIGIOUS, INTER-AGENCY, INTER-GOVERNMENT, CROSS-DISCIPLINARY CONNECTIONS PRIOR TO A DISASTER.
Connections among government levels and agencies, non-profit organizations, service providers, and faith-based groups are crucial following any disaster. These should all be part of the planning for preparedness. Teach positive coping and provide concrete plans about how all will come together before and after a disaster. Churches and schools can play a crucial role in teaching classes on “positive coping,” but they, too, need to be trained to do this.

D. EQUIP INDIVIDUALS AND COMMUNITIES FOR DISASTER PREPAREDNESS.
Prepared communities know what to do when disaster strikes. Pre-planned actions go into effect. This may be as simple as circulating a list of helpful Web sites that can be consulted in the emergency, a sequence of actions to re-route phones, wider education about relaxation/calming techniques, or actual guidelines for behaviour. For example, a task force is being established from the Assembly to examine the U.S. Terror Warning System to develop information about what citizens can do at each official level of threat—yellow, orange, or red. This might provide simple “scripts” for behaviours to be adapted in various contexts: at home, at work, at school, etc.

E. ENCOURAGE CORPORATIONS AND ORGANIZATIONS TO DEVELOP THEIR OWN DISASTER PREPAREDNESS PLAN.
Organizations and corporations in high-risk areas should have a terror attack/disaster preparedness plan. Organizations and corporations should, along with their fire or “terror drills,” develop plans of action for handling significant numbers of employees simultaneously killed or injured or, in the aftermath of an attack, significant numbers of grieving partners, probably amid disrupted communication systems.
2.2 BUILDING SOCIETAL RESILIENCE THROUGH BEST-PRACTICE TRAUMA TREATMENT

Many lessons have been learned from previous terror attacks and natural disasters around the globe. Misguided and unproven treatments can do harm. Best practice in trauma treatment includes the following components:

A. TRIAGE.

Triage of physical injuries or the sorting and assigning of treatment according to urgency, is a well established practice in medicine. Mental health concerns should also be triaged. Following a large scale disaster, a range of developmentally and culturally appropriate treatment modes, based upon varying levels of need, acuity, and intensity are required. During the time it takes to administer to physical needs, a systemic and comprehensive mental health screening program can be implemented. One example of this kind of program is found in the New York response to September 11th, which included a program in which Mount Sinai Medical Center conducted physical health screenings in coordination with Project Liberty crisis counsellors who provided psychological first aid and screened for more serious mental health disorders.

B. ALLOW FOR MULTIPLE TREATMENT METHODS.

Treatment methods should include and involve the survivors’ and communities’ own natural support networks. It is also important to ensure that the methods utilized are backed by a strong empirical research base. Some examples of evidence-based interventions include Cognitive-Behavioral Therapy (CBT) (e.g. Harvey, Bryant, & Tarrier, 2003), Eye Movement Desensitization and Reprocessing (EMDR) (e.g. Shapiro & Maxfield, 2002), as well as several other therapies. In administering any of these treatments, it is crucial to ensure they are enacted by trained and experienced counsellors. Damage can be done by well-meaning helpers who are not adequately qualified. One potentially effective approach revolves around the establishment in advance or in the immediate aftermath of a pool of qualified therapists. In New York, Dr Randall Marshall and his team trained 1500 mental health workers in proven trauma treatments so they could work in their own communities following the September 11th attacks. This proved an effective model.

C. DEVELOP A SCREENING PROCESS FOR THOSE PRESENTING AS HELPERS.

In the chaos of a disaster, many helpers flock to the scene. Communities should define in advance the various roles that will be enacted following an attack or disaster and the criteria for people qualified to fill those roles. Only qualified people trained for this specific disaster should then be allowed to work in that role. This qualification applies to all people working in the front lines: emergency workers, mental health workers, and clergy. Optimal planning would include advanced training of people for those roles (Butler, Panzer, & Goldfrank, 2003; Young et al., 2006). The wrong mental health treatment can do worse damage than no mental health treatment.
D. BUILD IN PROGRAMS AND STRUCTURES THAT FACILITATE COMMUNITY AND INDIVIDUAL BONDING.

Natural emotional bonding following an attack can be used to enhance community resilience. Examples of bonding events include “inter-religious” community theatre in Israel or the Bruce Springsteen concert held in Middletown several months after September 11. Despite their best benefits, bonding activities should be careful not to add to the isolation of some groups following an attack. “United We Stand” often means rejection of the “other.” Victims tend to get isolated as special groups with special status. While compassion is crucial, the attention victims receive and the activities in which they are expected to engage (while some are healing), may distort the time and attention survivors spend on actual grieving. “Victimhood” may also define a person according to an unwanted stereotype.

E. PLAN FOR DIFFERENT CHRONOLOGICAL TIMELINES FOR COPING AND HEALING.

The journey through grief is highly variable; there is no single universal response to trauma and no universal timeline for recovery. Assembly delegate, Ruth Pat-Horenczyk, noted that the essence of trauma treatment, under the guidance of a trained trauma specialist, is to provide the survivor with the safe environment and skills to mentally approach their trauma and retreat. Through a gradual iterative process of approaching the trauma and retreating, the survivor can incrementally incorporate the trauma experience into their psyche. The timing and extent of that integration is different for everyone. The process can take decades.

F. SCREEN FOR POST-TRAUMATIC DISTRESS UTILIZING A PUBLIC HEALTH APPROACH.

As noted above, school-based screening provides the most inclusive model for a non-stigmatizing, non-biased, normative environment for identifying the most affected children and adolescents. Similar programs can be established for adults, particularly first responders, through other natural community groupings. At the Pentagon, following September 11, 2001, an internet-based program served this role.

G. FACILITATE HARDINESS BY ENCOURAGING THE USE OF A COMBINATION OF COPING METHODS, PARTICULARLY EMOTION MANAGEMENT.

Research suggests that in the face of uncontrollable, unpredictable life-threatening events, focusing on managing the body’s emotional response can reduce anxiety (Gidron, Rueben & Zahavi, 1999). Such strategies can include relaxation, positive imagining, and distraction. Too much focus on the problem, such as obsession with identifying the terrorist on the bus or plane, can increase anxiety (although some of this vigilance can provide a sense of mastery and be preventative). Moving on from a crisis can also be enhanced by active coping – planning next steps, keeping active in constructive activities, and seeking social support for instrumental reasons. In contrast, excessive mental disengagement, behavioural disengagement, use of alcohol and drugs, or prolonged focus on and venting of emotions can inhibit recovery (Moos & Holahan, 2003; Silver et al., 2002).
H. ENCOURAGE PEOPLE TO TRANSLATE THEIR EXPERIENCES INTO WORDS.
Numerous studies have demonstrated that having people write or talk about emotional upheavals can reduce the anxieties and associated health problems linked to the upheavals. The construction of stories or narratives is particularly powerful in helping people to come to both an individual and collective understanding of anxiety-provoking events, both of which aid the healing process (Pennebaker, 2004). Timing of these strategies should be determined with the help of trained trauma specialists.

I. HELP FAMILIES MAINTAIN THEIR ROUTINES.
In a crisis, parents are simultaneously concerned about their own safety and that of their children. Parents and children should be encouraged to maintain regular activities and routines, which may include going back to work, attending school during or after times of great fear, or resuming other normal daily activities. School teachers need significant training and support in order to prepare for such crises. For example, training should outline the various ways in which children express distress, as well as the development of constructive and age-appropriate ways of helping the children make sense of the trauma.

J. ACKNOWLEDGE THAT THERE WILL BE A DIFFERENT AND “NEW NORMAL.”
Life does and will go on. New ways of being will be enacted that are different from before the experience of terror—with new routines, new people, and new roles. It is important to acknowledge that opportunities can come from the loss.

K. LIMIT TELEVISION VIEWING OF THE TERROR INCIDENT.
Research studies of both children and adults show that the degree of television exposure to terror attack-related coverage, regardless of direct physical or emotional exposure to an attack (where a family member or friend was killed or injured), is associated with post-traumatic stress symptomatology (Pfefferbaum et al., 2001; Marshall, 2004). Post-traumatic stress can be avoided by decreased media exposure.

L. ENSURE THAT THE RESPONDERS ARE TAKEN CARE OF.
Significant secondary trauma results if the first responders and caregivers (including the counsellors and teachers) are not provided with adequate support, psychological and physical. Symptoms of secondary trauma can be the same as those of primary trauma. Responders and caregivers should receive the same kinds of services provided to the direct survivors.

2.3 BUILDING SOCIETAL RESILIENCE THROUGH COMMUNITY INTERVENTIONS
Community interventions can be a part of prevention, individual cure, and community healing. Governments and
non-government agencies can take the following steps:

A. FACILITATE AN IMMEDIATE SUPPORT NETWORK FOR THE SURVIVORS FOLLOWING AN ATTACK.

Local community and family networks should be activated as soon as possible to help survivors quickly connect with family, friends, and neighbours. These networks should provide support and practical assistance and locate survivors of previous terror attacks who are willing to share what worked for them. Faith-based networks can also be critical.

B. DESIGN AN OUTREACH PROGRAM TO CONDUCT CONSISTENT IN-COMMUNITY FOLLOW-UP BY EXPERIENCED TRAUMA TREATMENT SPECIALISTS, EVEN IF SURVIVORS ARE NOT PRESENTING WITH SYMPTOMS.

In-community follow-up needs to be conducted periodically for several years after the incident. Timing of outreach is crucial, and interventions should be based on lessons learned from experienced trauma treatment specialists from communities who have previously dealt with terror—for example, Israel, New York, Bali, and London. It is also important to consider that many people are still inhibited to consult mental health professionals because of differences in value orientation, lack of awareness of services, the stigma involved, and financial considerations (Naturale, 2006). They therefore tend to turn more to relatives and friends and, later, to fellow survivors. Outreach should thus include the dissemination of psycho-educational information to survivors’ relatives and friends on coping skills for both survivors and carers of survivors. Post September 11, 2001, Project Liberty in New York advertised via television, radio and subway ads that it was OK to have a stress response to such an abnormal event and that help could be attained by calling their hotline. Faith-based groups can also be crucial in community outreach programs, but, as in all interventions, clergy and others must be trained in best-practice responses.

C. HELP CITIZENS UTILIZE THEIR OWN RESOURCES IN THEIR OWN COMMUNITY.

Communities should develop prototypical plans for quick mobilization and training of volunteers from diverse sources. For example, all volunteers in the local schools and churches across the country could be taught phone/Internet chain communication techniques that could be immediately activated in a disaster.

D. ENCOURAGE SUPPORT GROUPS AND OTHER STRATEGIES FOR ACTIVE RATHER THAN PASSIVE COPING.

Citizens should be encouraged to get involved in cooking for neighbours, political activism, organizing others for community service/support, assisting others in travelling the bureaucratic maze—anything to assist productive “doing.” Note that one trap of support groups is to reinforce the sense of victimization. Active coping can manifest
in spontaneous community volunteerism. For example, following September 11, two local Middletown, NJ women founded FAVOR—Friends Assisting Victims Of TerroR. FAVOR is a grass roots, hands-on, support network resulting from citizens wanting to do. FAVOR grew to a volunteer team of over 90 Middletown residents who started out trying to help affected families maintain a sense of normalcy. They solicited and distributed practical and financial support, did the shopping, provided childcare, and organized accounting, vacations, Christmas gift baskets, and lawn mowing—all with correspondingly strong emotional support.

3. FACILITATE COLLABORATION TO ENSURE BEST-PRACTICE INTERVENTION

Facilitate global, national, community, cross-cultural, and inter-disciplinary collaboration on preparedness, as well as curative and community interventions.

A. COLLABORATE ACROSS PROFESSIONS TO ENSURE CROSS-FERTILIZATION OF RESEARCH AND BEST PRACTICE, AS WELL AS COLLABORATION ACROSS NATIONAL AND POLITICAL BOUNDARIES.

Experienced and knowledgeable professionals should reach out beyond normal professional, communal, cultural, or national boundaries in order to collaborate and work together. Efficiency and effectiveness is born of communication, collaboration, and non-duplication.

B. ENSURE BOTH EVIDENCE-GENERATING AND EVIDENCE-DRIVEN TRAUMA INTERVENTIONS.

It is imperative that the trauma interventions supported by individuals and communities be those that have a strong chance of reducing trauma without causing more psychological problems for survivors. The best way to support this is to ensure that the trauma interventions are based on existing practices supported by research. However, there are many therapeutic approaches that may work but are currently supported by anecdotal or insufficient existing research to be fully considered evidence-based. Post-trauma interventions are an important domain for gathering evidence on the effectiveness of the interventions used. Partnerships between researchers and people who are conducting interventions provide the opportunity for increasing the evidence base of existing therapies. However, it is critical that only therapies with an existing evidence base demonstrating that they are likely to help and that they will not cause additional harm be used in any response to terror attacks or natural disaster. A new or incompletely developed therapy may cause more harm than good.

C. COLLABORATE ACROSS RELIGIONS AND COMMUNITIES WHO HAVE EXPERIENCED TERROR.

Middletown America (Sheehy, 2004) was a good example of cross-religion and community collaboration: the rabbi,
the Episcopal minister, the Muslim cleric and the Presbyterian minister worked together not only to support each other in difficult roles, but also to provide visionary leadership to the whole Middletown community. Similar healing resulted from the linking of New York recovery teams with Oklahoma City recovery teams. The interfaith and intercity connections forged prior to a disaster will provide crucial support following a disaster.

D. CONTINUE THE GLOBAL DIALOGUE.
Numerous cross-cultural and cross-disciplinary task forces have been established to continue work on specific areas identified at the Assembly. Psychology Beyond Borders (www.psychologybeyondborders.org) is the key organization designed to continue the global discussion.

E. SCREEN THE DOCUMENTARY: “BEYOND FEAR.”
A documentary entitled “Beyond Fear” was made about the work of the Assembly. The documentary will form the basis of community workshops with service providers and emergency workers around the world. A set of training guidelines accompanies the film for various target audiences. Utilizing these tools, a series of workshops can be conducted to train practitioners as trainers to further disseminate the recommendations into a diverse array of settings. Plan a screening in your organization/community. Contact info@psychologybeyondborders.org for details.

4. EXPLORE AND MODEL ALTERNATIVE MEANS OF CONFLICT RESOLUTION.
Nations and communities must seek alternative ways to solve terrorism. The most effective way to reduce the trauma of a terrorist attack is to prevent that attack from occurring. Strategies which reduce the likelihood of terror attacks, including supporting alternative means of conflict resolution, are an important part of the psychological response to terrorism.

A. TEACH AND PRACTICE EFFECTIVE CONFLICT RESOLUTION BETWEEN PEOPLES, BETWEEN INDIVIDUALS, AND BETWEEN CULTURES.
Political leaders must learn and enact these skills. Teachers can also teach and model effective conflict resolution in classrooms, as can parents in the home.

B. TEACH AND PRACTICE UNDERSTANDING AND TOLERANCE.
Teach and practice understanding, tolerance, forgiveness, and healing between peoples, between individuals, and between cultures. Also teach the dangers of stereotyping.
C. PROMOTE SHARED HUMANITY.
When people view pictures of diverse families from around the world, research shows that if they are encouraged to focus on commonalities, the effects of fear or hostility toward the “other side” can be reversed (Pennebaker, 2004).

D. FACILITATE CONSTRUCTIVE AND EFFECTIVE CONFLICT RESOLUTION AT TOP LEVELS.
Political, community, and organizational leaders can learn from the experts about conflict resolution and can put this knowledge into practice in order to facilitate effective, mutually satisfying conclusions to negotiations.

E. IDENTIFY AND TREAT HATRED AND AGGRESSION (AND REASONS FOR IT) IN THE YOUNG.
Encourage and develop cross-cultural socialization and education programs to break down hatred and stereotyping. As a result of Israeli and Palestinian delegates talking together at the Assembly, at least one such joint socialization and treatment project has been implemented in Gaza.

F. DEVELOP EDUCATION AND THERAPIES THAT RECOGNIZE GOOD AND EVIL IN ALL.
Help individuals and groups cope realistically with threats and dangers without employing typical defensive strategies such as “black–white” thinking. Labelling allies as fundamentally good and enemies as fundamentally evil contributes significantly to the development of group prejudice and interferes with the possibility of diplomacy. We need to educate people about the dangers of acting out retaliatory impulses and about the increased likelihood of an escalating, negative spiral of violence if retaliation is the only enacted solution.

5. ENCOURAGE AND SUPPORT “MODERATES” RATHER THAN FACILITATING “EXTREMISTS.”

An important element of meeting the threat of international terrorism is to do everything we can to harness and assist the voices of moderation within the Islamic world who reject the tactic of terror. A comprehensive data bank should be established of these names, and plans drawn up as to how best to provide them with the most relevant support. Obviously, differing circumstances will dictate a selective approach to determine what form of support is most appropriate in each case.

HON. BOB HAWKE, former Prime Minister of Australia
November 2004

Violent terror attacks are often perpetrated by desperate extremists trying to promote a specific political agenda. As long as such groups have the resources to socialize young people, to spread negative messages that resonate with disillusioned youth, to train those youths in terror tactics and to widely distribute extreme interpretations of Western culture or events to the general Middle East population, hatred and division will continue.
Alternatively, if Western democracies direct resources—financial, educational and material—to moderates (who reject terror) so that they might also socialize young people and spread positive messages of peace, tolerance, and working together, then the influence of terror advocates will be diluted. Such support would obviously be preceded by governments and aid agencies identifying the tolerant moderates so that they can be supported.

The second wave of attempted bombings was very frightening, because it showed that the people who are most likely to do this are just young, susceptible men. The thing that we have to work out, I think, is why they are susceptible to such a message.

GILLIAN HICKS, Australian survivor, London terror attacks, July 2005
Australian Women’s Weekly, October 2005.
STRATEGIES FOR THE MEDIA

RESEARCH SINCE 9/11 HAS REVEALED that the media was the primary source for transmission of the stressor, the terror, propagating aspects of the terror experience far beyond those directly exposed (Butler, Garlan & Spiegel, 2004). Such findings support the importance of the media’s role in conveying accurate information about the limits of a threat, educating the public regarding expected reactions, as well as adaptive coping strategies, and enhancing a sense of community.

STRATEGIES FOR THE MEDIA TO FOLLOW:

- Collaborate with decision-makers and mental health experts in a partnership on how best to report terror alerts and terror attacks.
- Become educated about responsible reporting of large scale trauma. Visit www.dartcenter.org
- Help media coverage to change from sensationalist to deliberative, from alarmist to informative.
- Be an educator.
  For example, help diffuse the confusion about the U.S.A. color-code alert system by simple explanations.
- Collaborate with educators, researchers, clinicians, and government agencies in a proactive campaign of public health preparedness.
- Be aware of the traumatizing personal impact of photographing/interviewing survivors and relatives.
  For example, when Nerissa McCartney flew to the Darwin Hospital to see Jason for the first time after he had been airlifted from Bali she was accosted by journalists wanting a story, with no privacy for her shock or grief at seeing his horrific injuries for the first time (McCartney, 2003).
- Be aware of the potential for re-traumatizing survivors and their relatives with the images/words and frequency of reminders of an event.
- Be aware of the impact upon children of those words and images.
- Stop showing gruesome images of dead and injured bodies. Less traumatizing images can still convey “truth.”
- Report only the facts, not exaggerations or embellishments.
  For example, salience and frequency of terror-related stories exaggerate the probability of citizens being affected by a terror attack. Reporting of terror-related activities are far higher than the actual incidence or likelihood of a terror attack.
- Be aware of the damaging impact of particular words
  For example, the word “closure” suggests that the suffering is going to end. There may never be “closure.”
- Become a partner in disseminating resilience-related information.
- Heighten public awareness of positive events and reasons to celebrate.
- Join a task force with selected Assembly delegates to enhance best-practice for the media who report terror.
- Treat your own trauma by seeking support from colleagues or counselors. Visit www.dartcenter.org
- Encourage your news organization to set up support mechanisms for reporters covering trauma.
HELPING THE CHILDREN

MANY OF THE STRATEGIES DETAILED in the previous sections also apply to children. However, parents and helpers should ensure that application of any intervention is appropriate to the child/adolescent’s developmental and cultural needs.

NATIONAL AND COMMUNAL STRATEGIES

- Ensure preparedness of schools, including training of teachers, staff, parents, and students.
- Ensure preparedness of NGOs and faith-based groups, including training in the psychological impacts of trauma.
- Community leaders should provide simple calming explanations.
- Help teachers, staff, and students maintain routines, while providing support and acknowledging the pain and grief.

FAMILY AND INDIVIDUAL LEVEL STRATEGIES

- Help children understand that terrorists want us to be scared, but that the actual risk of any one child being a victim is virtually zero.
- Provide reliable information and dispel baseless rumours.
- Reassure children that in the very unlikely event of an attack in any one area of the country, the government is doing all it can to handle it when it happens.
- Limit exposure of children to images of terror by:
  - turning off televisions and radios if the focus is on war and terror
  - conceal newspapers and magazines with horrific photos
- In the event of an attack, maintain routines as much as possible.
- Share and help children remember previous successful coping strategies.
- Provide children with simple, non-dramatic explanations of what happened.
- Provide children in advance with simple explanations of security arrangements at airports, museums, government buildings, public events, etc. so that they are prepared for security scenes when travelling or attending high security functions.
- Teach children active coping strategies and engage in both functional (such as helping around the house) and play activities.
- Help children explore and deal with their emotions, particularly their grief, through talking, art, music, sport, and theatre (Gidron, Reuven & Zahavi, 1999).
- Ensure family support and social solidarity offered to the family also includes the children. Hugs and other forms of physical comfort are very needed by children, especially if they have lost a family member.
- Teach children self-calming, relaxation, positive visualization, and positive self-talk.
- Assist children with developing their problem-solving and decision-making skills, which may have been paralysed by stress (Berger, 2004).
- Teach children non-violent conflict resolution and constructive alternatives to revenge.
- Emphasize the positive commonalities of all humanity.
- Seek skilled professional help for both the adults and the children. Trained and experienced trauma specialists for children can best handle the specific effects displayed by children who have experienced terror.
CHILD-FOCUSED WEB SITES

Some Web sites listed below are U.S.A.-based. Most countries have their own national associations for psychology, psychiatry, social work etc., and these can be consulted in the affected country also.

American Psychiatric Association Help Center: http://www.psych.org
American Psychological Association: http://www.apahelpcenter.org
Child Trauma Academy: http://www.childtrauma.org
Center for Effective Parenting: http://www.parentinged.org/handout3/Specific%20Concerns%20and%20Problems/terrorism
Coping With the Stress of Terror Attacks: http://coping.stanford.edu
International Society for Traumatic Stress Studies: http://www.itss.org/terrorism/russia.htm
National Institute for Trauma and Loss in Children: http://www.tlcinst.org
National Association for School Psychologists: http://www.nasponline.org
National Center for Children Exposed to Violence: http://www.NCCEV.org
National Institute for Trauma and Loss in Children: http://www.tlcinst.org

BOOKS FOR CHILDREN

Shapiro, L. (2002). *Will they fly a plane into our house? How to talk to children about terrorism.* Published by Play2Grow. www.play2grow.com

MANAGING THE PSYCHOLOGY OF FEAR AND TERROR

DEFINITION OF TERMS AND ACRONYMS

BYSTANDER (INTERVENTION) EFFECT
The phenomenon that the more people present when help is needed, the less likely any one of them is to provide assistance. Once thought to be a symbol of the dehumanizing urban environment, the effect is now known to be quite general. Essentially, the more people about, the more likely each is to assume that someone else will provide the help—hence, no one helps (Dictionary of Psychology, 1985). The bystander effect can be overcome by any individual present taking the lead in designating roles to standers-by on how to seek help.

COGNITIVE BEHAVIOR THERAPY (CBT) (OR COGNITIVE THERAPY)
CBT combines two kinds of psychotherapy—cognitive therapy and behaviour therapy. Behaviour therapy helps weaken the connections between troublesome situations and habitual reactions to them. Reactions can include fear, depression or rage, and self-defeating or self-damaging behaviour. CBT also teaches how to calm the mind and body so that people can feel better, think more clearly, and make better decisions. Cognitive therapy teaches how certain thinking patterns are causing symptoms—giving a distorted picture of what’s going on in the person’s life, and causing anxiety, depression, or anger for no good reason, or provoking ill-chosen actions. When combined into CBT, behaviour therapy and cognitive therapy are tools for stopping symptoms and getting life on a more satisfying track.

EVIDENCE-BASED PRACTICE (EBP)
EBP is one approach to improving the impact of practice in medicine, psychology, social work, and nursing and allied fields. While all professions have directed attention to “evidence” for many years, EBP puts the emphasis on the results of experiential comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both. In the case of psychology/psychiatry, it is the practice of treatments, or interventions, that are based on randomized control trials whereby participants are randomly allocated to either a treatment or a control condition. These interventions work with the following methods: behaviour modification, relaxation, stress management, anger management, parent management training, cognitive restructuring, as well as others.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)
EMDR is an information-processing therapy and uses an eight-phase approach. During EMDR the client attends to past and present experiences in brief sequential doses while simultaneously focusing on an external stimulus. Then the client is instructed to let new material become the focus of the next set of dual attention. This sequence of dual attention and personal association is repeated many times in the session. After much initial work, the client is instructed to focus on the image, negative thought, and body sensations of concern while simultaneously moving his/her eyes back and forth following the therapist’s fingers as they move across his/her field of vision for 20-30 seconds or more, depending upon the need of the client. Although eye movements are the most commonly used external stimulus, therapists often use auditory tones, tapping, or other types of tactile stimulation. The kind of dual attention and the length of each set are customized to the need of the client. The client is instructed to just notice whatever happens. After this, the clinician instructs the client to let his/her mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. This form of therapy has been shown to be very helpful for people who have witnessed horrific violence or great shock.
POST TRAUMATIC STRESS DISORDER (PTSD)

PTSD is a psychiatric disorder that may occur following the experience, or witnessing, of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People with PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can be severe enough and last long enough to significantly impair the person’s daily life.

PTSD is marked by clear biological changes as well as psychological symptoms. PTSD often manifests with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person’s ability to function in social situations or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.
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USEFUL WEB SITES

Academy of Traumatology: http://www.traumatologyacademy.org
American Art Therapy Association: http://www.arttherapy.org
American Psychiatric Association: http://www.psych.org
American Psychological Association: http://www.apa.org
American Psychological Association Help Center: http://www.apahelpcenter.org
Center for Services in the Aftermath of Violence and Extreme Stress: http://www.psychiatry.uchc.edu/saves/
Center for Trauma Response, Recovery and Preparedness at the University of Connecticut Health Center, Department of Psychiatry: http://www.CTRP.org
Christian Research Association: http://www.cra.org.au
Child Trauma Academy: http://www.childtrauma.org
Coping With the Stress of Terror Attacks: http://www.coping.stanford.edu
Green Cross Foundation: http://www.greencross.org
International Council of Nurses (ICN): http://www.icn.ch/terrorism.htm
International Red Cross: http://www.icrc.org
National Center for Children Exposed to Violence: http://www.NCCEV.org
National Center for PTSD: http://www.ncptsd.org
National Institute for Trauma and Loss in Children: http://www.tlcinst.org
National Mass Fatalities Institute: http://www.nmfi.org
Office for Victims of Crime (OVC): http://www.ojp.usdoj.gov/ovc
Public Broadcasting System (PBS): http://www.pbs.org/newshour/bb/media/july-dec01/patriotism_11-6.html
Salvation Army: America: http://www.salvationarmy.org
Systems Centered Training: http://www.systemscentered.org
Teaching, Learning & Technology Group (TLT): http://www.tltgroup.org/Share/CopingTerrorismGrief.htm
United States Institute of Peace: http://www.usip.gov
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JAMES PENNEBAKER, DARIO PAEZ AND BERNARD RIME

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The strategies outlined in this paper were derived from the research, the written submissions, and the Assembly discussions of almost 100 of the world’s experts on managing the psychology of fear and terror.

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Psychology Beyond Borders
www.psychologybeyondborders.org

Psychology Beyond Borders (PBB), with its international network of expert psychologists, psychiatrists and social workers, specifically focuses on the psychosocial impacts of terror attacks, armed conflict and natural disasters. The PBB mission combines psychosocial field work and research to contribute to the body of knowledge about the healing or harming effects of various interventions, with the ultimate goal of informing public policy and educating individuals, communities and policy makers. PBB aims to help facilitate the most effective strategies for prevention, preparedness and response to traumatic events.