THE PSYCHOLGICAL ASPECTS OF TERRORISM:

THE PSYCHOLOGICAL CONSEQUENCES/IMPACT OF TERRORISM

A SURVEY OF LITERATURE, AND LIST OF EXPERTS AND RESEARCH INSTITUTES

NETTA SHAKED, PhD

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OUTLINE

CHAPTER I

PSYCHOLOGICAL ASPECTS OF TERRORISM

Overview

The impact of terrorism, as a phenomenon that influences individuals, communities, and nations globally, has reached a level that many terrorism experts would have never expected even just a few years ago. In line with the changing landscape, the *psychological* impact of terrorism, as a force that influences the psyche of the individual, the emotional reactions within communities, and the psychological counter-terrorism worldview, has also reached a level and complexity which many trauma psychologists would have never expected several years ago. Indeed, psychology experts in the field point out that in the year 2005—four years after September 11, 2001, and some three decades after constant terrorist attacks in Israel—psychological responses to terrorism "are neither simple nor easily predicted" (Danieli, Brom, & Sills, 2005, p. 776).

A great deal of conceptual and empirical literature has been published recently, primarily in the aftermath of September 11 and subsequent international terrorist attacks. Along with this outpour of publications, institutions have focused on the topic of the psychological consequences of terrorism, and scholars have developed significant expertise in this emerging field. More specifically, empirical research on the psychological consequences of terrorism has become increasingly pervasive (Blumberg, 2002), as academics and practitioners continue to recognize the immediate and delayed psychological impact of terrorism on various segments of the population (Stout, 2004; Levant, 2002). As McCabe, Siegel, Everly, Heitt, and Kaminsky (2004) point out, "that terrorist acts can have profound physical, social, political, and economic effects on the citizens of the United States

is indisputable; however, it is the psychological impact of such incidents that could become one of the country's greatest challenges of the 21st century" (p. 197).

Naturally, the public health consequences—for policy makers—and the economic and legal consequences—for businesses—are also of import in the realm of the psychological aspects of terrorism. McNally, Bryant, and Ehlers (2003) underscore "how high the financial stakes can be in the field of traumatic stress, and how tensions can arise between the goals of clinical science and business" (p. 74). Of particular interest is an anecdote of personal communication, shortly after September 11, which the authors had with a reporter: executives of 80 companies with offices in the World Trade Center were planning on engaging commercial debriefing organizations to prevent PTSD among their employees. Apparently, the executives feared lawsuits should they fail to debrief their employees. However, as McNally et al. (2003) note, debriefing could also pose a liability issue, given its inconsistent empirically documented efficacy.

While the public health, economic, and legal aspects of the psychological impact of terrorism are indeed of paramount importance, and can inform our understanding of terrorism, they will not be addressed in this paper. Nor will this paper deal with the psychological impact of terrorism on decision-making by political leaders, on the world of business, on the economy, or on the media. These topics merit papers exclusively devoted to these types of consequences.

What will be addressed in this paper, are the *psychological consequences of terrorism on the victims, the general civilian population, and the first responders to terrorist acts*. Along these lines, this paper provides an integrative review of the literature on the psychological consequences of terrorism involving conventional terrorist acts.

Previous Literature Reviews

Several reviews of the literature have already been conducted. Blumberg (2002) published a bibliography that features work which focuses narrowly on this topic. The author classified works into the following categories: (a) general works and overviews; (b) effects on children and adolescents; (c) psychodynamic and other effects on adult victims; (d) crisis intervention; (e) emphasis on particular geographic locations; (f) specific forms of terrorism (e.g., nuclear, biological, chemical); (g) understanding and dealing with terrorists; and (h) interdisciplinary and special topics (e.g., interfaces with politics, history, ethics). Emphasis was given to recent works (up until 2002) that contained the terms terrorism or terrorist(s) in their titles or subject indexing. The listings were based mainly on searches of three databases, including PsycINFO.

Miller and Heldring (2004) also provided an integrative review of literature, geared towards primary-care settings, which were assumed to be the first point of contact within the health care system for most people. In their examination of the existing research literature regarding the psychological impact of the September 11 terrorist events on adults and children, they aimed to identify directions for future research that will guide resource development for health care providers. Their review was organized around three themes: (a) prevalence of psychological and somatic symptoms immediately after September 11; (b) trends in symptom reporting over time; and (c) correlates or predictors of psychological symptom severity and resilience. The results of these studies were discussed in relation to studies of previous natural disasters and other terrorist attacks.

Yet another recent review of the literature by Doty, Rohde, and Lating (2004)

presented selected annotated journal resources. The references cited by this article focused on the psychological effects of, and possible interventions for, crisis situations. Crisis situations were defined broadly: to include both terrorist acts, such as September 11 and the Oklahoma City bombing; and also other crisis situations, such as sexual abuse, childhood trauma, posttraumatic stress disorder, substance use disorders, and suicide.

Yehuda and Hyman (2005) performed a comprehensive review of the literature, to address the still "troubling gaps in our knowledge" (p. 1773) about the long-term effects of terrorism on the brain, behavior, and physical health; the risk factors for those most prone to be affected by terrorism; and interventions that might promote resilience at an individual and general community level. This literature review, along with an accompanying research agenda, consituted a white paper published in October 2005 by the Interdisciplinary Task Force on Terrorism of the American College of Neuropsychopharmacology.

Considering the plethora of publications both during and after the publication of the aforementioned literature reviews, and given their very specific foci on particular psychological aspects of terrorism, there is still a gap between what we know, and what we know we need to know. This paper attempts to bridge the extant gap by capitalizing on what experts have already established as known, while also exploring that which has been established as unknown.

Purpose

The purpose of this paper is to provide a comprehensive review of the literature on the psychological consequences of conventional terrorist acts, as they pertain to the victims, the general civilian population, and the first responders. This paper: (a) summarizes and classifies existing research on the psychological impact of terrorism; (b) identifies institutes

that specialize in the study of terrorism in general and its psychological impact, specifically; (c) lists experts who specialize in the former and the latter; and (d) provides a list of publications (i.e., books, articles, etc.), databases, and websites which focus on this field.

Significance of the Study

It is hoped that meeting the above four objectives will contribute to the advancement of knowledge and further our understanding of the psychological impact of terrorism by identifying: (a) what we have learned thus far and (b) what we have yet to learn from future research—as articulated by expert researchers and scholars in the field.

Terrorism and Psychological Trauma

To date, there is no single, internationally acceptable definition of terrorism. The Institute of Medicine defines terrorism as "the illegal use or threatened use of force or violence; an intent to coerce societies or governments by inducing fear in their populations; typically with ideological and political motives and justifications; an 'extrasocietal' element, either 'outside' society in the case of domestic terrorism or 'foreign' in the case of international terrorism" (Stoddard & Geller, 2005, p. 362). An important aspect of terrorism is that it hits civilian 'innocent bystanders' who just happen to be there during the act.

As stated by Miller (2003), "in essence, terrorism is the 'perfect' traumatic stressor, because it combines the elements of malevolent intent, actual or threatened harm, and unending fear of the future" (p. 258). Indeed. The very purpose of terrorism fully meets Criterion A of the American Psychological Association Diagnostic and Statistical Manual of Mental Disorders' (DSM-IV) diagnostic classification of posttraumatic stress disorder. In fact, as noted by Miller, researchers have identified several elements of terrorism that are congruent with traumatic stress: use of violence as a method of persuasion, influence, and

intimidation; targets with propaganda value; unconventional military tactics; and loyalty to the terrorist organization.

Although terrorism is a particular type of traumatic event, certain aspects of the psychological impact of terrorism converge with most types of traumatic events. These common features are: (a) the degree of exposure, (b) availability of social support or lack thereof, (c) the amount of disruption in daily life activities, and (d) the level of social disorganization.

Wilson and Rosenthal (2004) state that "a tentative conceptual model is beginning to emerge from the accumulating fragmentary empirical findings" (p. 588) regarding the psychological trauma of terrorism. Post-disaster distress appears to be a function of: (a) the extent of exposure, (b) pre-morbid psychological distress, (c) the immediate distress response to the disaster, (d) the amount of time elapsed between the experience and/or observations of the trauma and the distress symptoms, and (e) the additional traumatic exposure post-occurrence of the disaster.

Interestingly, even the clinical conceptualization of what makes a terrorist event traumatic is changing. In the past, it was assumed that a subjective sense of imminent personal threat was the etiology. Hence, the diagnostic focus was exclusively that of posttraumatic stress disorder (PTSD). However, in light of the widespread study of terrorism as a new and constantly evolving type of psychological trauma, researchers have expanded the concept to include not only imminent personal threat, but also observational experience, indirect trauma, or mass media trauma. Moreover, researchers have shifted the psychological consequences to include not exclusively PTSD, but also a spectrum of related sub-threshold conditions, dubbed posttraumatic stress *symptoms*.

CHAPTER II

METHODOLOGY

Procedures

Published Research and Scholarly Works

Published research and scholarly works, with publication dates up through 2005, were culled utilizing PsycINFO, a database published by the American Psychological Association. This database is recognized in the discipline of psychology as the most comprehensive index to research journals, books, and dissertations in psychology. It indexes articles in 30 languages and 50 countries, as well as English language books and book chapters published worldwide.

Inclusion of published research and scholarly works in the sample was established via the application of a broad criterion of the search term *terror** (i.e., to include terror, terrorist(s), and terrorism), in the major descriptor or minor descriptor field, and the search term *psycholog** (i.e., to include psychology, psychologist, and psychological—so as to 'catch' psychological consequences)—in the major descriptor or minor descriptor field. This search yielded approximately 2000 entries.

A preliminary search was conducted with the terms *terror** together with various synonyms, suggested by PsycINFO for *psychological consequences* (i.e., aftermath, attributable, attribute, attributed, consequence, consequences, consequential, effect, effects, following, impact, impacting, impacts, implication, implications, influence, influencing, influential, meaning, meaningfulness, results, resulting, results, sequel, sequelae, significance, signify, and signifying). In order to cast the broadest net possible and to capture

the most data, the search was extended to incorporate the aforementioned combination of the paired terms *terror** and *psychol**.

It is important to note that the term *terrorism* first appeared in PsycINFO in 1982. However, the records searched for the purposes of this paper were dated from the year 1806 until the present.

Experts

Experts were culled by the author of this paper—subjectively and impressionistically—via analysis of the type, number, and significance of contributions to the above-mentioned list of entries. In addition, expertise was corroborated with peer and colleague endorsements throughout the publications. The experts are listed in Appendix B.

Institutes (Psychological Aspects of Terrorism and Terrorism and Counter Terrorism)

Like experts, institutes were culled from the content of the above-mentioned entries and their respective references and/or bibliographies. Moreover, a google.com search was conducted to search for those heretofore un-referenced, or new, institutions. See Appendix C.

Bibliography

While not an annotated bibliography, as it is strictly defined by librarians, this paper constitutes a review/summary of works that focus narrowly on the topic of the psychological consequences of terrorism. Studies reviewed and cited are intended to be indicative, rather than exhaustive of the whole literature.

A comprehensive, alphabetical (by first author) list of published works is included in Appendix A. It provides a more thorough depiction of the nature, trends, and foci of extant scholarly works—in the broader context of the psychological aspects of terrorism. It should be noted that even this long list is not completely exhaustive (see limitations below).

Limitations

The limitations of this review are two-fold: (a) the use of PsycINFO as the sole, exclusive database, and (b) the exclusion of certain types of published works.

PsycINFO

In addition to PsycINFO, several other existing databases may have yielded a more comprehensive, thorough inventory of relevant material. Some examples of such databases include, but are not limited to, MEDLINE, ERIC, LEXIS/NEXIS, and BISAC. However, because of the already large number of citations obtained through the use of PsycINFO alone (close to 2,000 records) and considering the prominence of PsycINFO in the academic psychological community, it was determined that—for the purpose of this paper—PsycINFO would likely yield the richest, most relevant search results.

Exclusion Criteria

Excluded from the review of the literature were those items deemed as irrelevant, or less than pertinent, such as individual case histories, pop-psychology materials, and publications which focused primarily on the nature of terrorists and/or terrorist organizations. In addition, the literature which dealt with chemical terrorism or bioterrorism was excluded from this review because of its accompanying confounding factors in the conceptualization of psychological symptoms. Chemical or biological attacks do, like conventional terrorist attacks, produce psychological impairment at the individual and community level. However, chemical and biological agents do not have the same tangible, visible, and audible components as do conventional terrorist acts, such as explosions, suicides, etc. Experts in the field such as DiGiovanni (1999) echo the same: “a chemical or, even more so, biological incident poses a sudden, unanticipated, and unfamiliar recurrent threat to health that lacks

sensory cues, is prolonged or recurrent, perhaps is contagious, and produces casualties that are observed by others" and that "these are factors that historically, have spawned fear, panic, and contagious somatization" (p. 1502). Yet, as Danieli et al. (2005) point out, "the threat of bioterrorism raises additional complications since bioterrorism is likely to create casualties presenting [with] a mix of symptoms related both to the biological agent itself and the terror experienced" (p. 782).

CHAPTER III

EFFECTS ON MENTAL HEALTH

With the dearth of publications, both empirical and conceptual, specifically on the psychological consequences of terrorism, the works discussed in this chapter are classified and categorized by salient themes. Each publication is categorized by its most salient theme, although, clearly, most works are not limited to only one theme (or in many cases, even just to two or three).

Thus, in order to remain succinct and to avoid redundancy, the works are discussed only once in this chapter. This chapter organizes the effects on mental health by: (a) type of impacted population; (b) non-US regions (i.e., if research was conducted about a terrorist act which occurred outside the US, the specific city or country most pertinent to the research); (c) US region--specifically New York City populations (i.e., NYC children and adolescents, NYC adults, NYC women, and NYPD), National Samples (i.e., national studies on children, adolescents, and adults), and the Oklahoma City Bombing; and (d) level of exposure to the act of terrorism.

Type of Impacted Population

Much of the research focused on a specific sample of the population. These populations are discussed below in alphabetical order.

Aid Workers/Emergency Personnel

Johnson Jimenez (2005) states that in the past 20 years, there has been an increasing focus in the mental health literature on serving the psychological needs of emergency responders and disaster relief personnel. In line with this focus, the American Red Cross initiated the Disaster Mental Health Services (DMHS), in response to the perceived need for

psychological services for victims and disaster relief workers. This study evaluated the utilization of Disaster Mental Health Services by disaster relief workers who responded to the terrorist attacks of September 11, and the relationship of that utilization and later distress. One year after the September 11 terrorist attacks, a survey was mailed to 6,055 American Red Cross paid staff and volunteers who performed relief work within the first three months following the attacks; of these, 3,055 participants responded. Results showed that older workers and men endorsed significantly fewer symptoms of traumatic stress, depression, anxiety, and anger. Irrespective of the 'exit' debriefing, the majority of participants did not exhibit lower levels of posttraumatic stress symptoms, anger, depression, or anxiety scores. However, the results showed that having participated in a debriefing was related to lower posttraumatic stress symptoms for younger workers and women. Consequently, the authors concluded that the usefulness of the debriefing was "lukewarm at best." Other notable findings include: women and older individuals had more contact with DMHS personnel than men and younger individuals, and workers in indirect service roles showed slightly higher depression symptoms than workers in direct service roles.

McCaslin, Jacobs, and Meyer (2005) investigated the impact of negative life change occurring in the year following the September 11 terrorist attacks on levels of distress among 757 Red Cross Disaster Services Human Resources employees, who are part of the national disaster team, and volunteers who responded to this disaster. The authors noted that the American Red Cross is the largest non-governmental organization responding to disasters in the United States. Results highlighted the importance of life experiences in the year following disaster response and, therefore, the authors emphasized that education and follow-up services provided to disaster workers prior to, and following disaster assignment are

paramount. Results indicated that negative life change, in the year following disaster response, was correlated with the relationship between disaster response and symptoms of depression; and was partially correlated with the responses between disaster response and posttraumatic stress and anxiety symptoms. “Consistent with previous research, results suggest that experiencing negative life change in the year following disaster relief work may interfere with the recovery process for disaster relief workers” (p. 250). Suggestions for monitoring disaster-related stress during and following assignment were provided.

Gonzalez Ordi, Miguel Tobal, Vindel, and Iruarrizaga (2004) sought to explore the psychological aftermath of traumatic exposure in emergency personnel involved in rescue efforts and first aid after the March 11, 2004 terrorist attacks in Madrid. In their investigation of a group of 165 individuals (30.1% males and 69.9% females), with a mean age of 34.9 years, they found that emergency personnel manifested intense peri-traumatic reactions, with higher prevalence than in the general population, due to a high degree of exposure to traumatic consequences of the bombings. However, due to the fact that they were mostly well-trained professionals and with previous experience in disaster management (the sample included mental health workers, policemen, physicians, etc.), the authors posited that emotional management was functional, and served to prevent chronic symptoms.

Freedman (2004) conducted ethnographic research to explore the values and social and emotional characteristics of September11 responders, based on in-depth interviews conducted with ‘ground zero’ first responders, firefighters, police officers, fire and police chaplains, and media persons. Results showed that diagnostic constructs, such as posttraumatic stress, may be too limiting; that is, they do not account for the individual responses and the respective existential factors which impacted the resilience of these

responders. Moreover, findings revealed that responders' social background, the occupational community to which they belonged, and the coping mechanism for working through disaster and death—which they had learned through their professional training and socialization—were significant factors. The author noted several caveats regarding treatment, which emerged from the research, vis-à-vis clinical implications; there are: behavior and experiential accounts that may be considered 'abnormal' under most circumstances are usually normal responses to abnormal circumstances and situations; emotional numbing and psychological distancing may be useful and self-adaptive tools; high cohesion groups may have their own ways to make meaning, diminish stress, and maintain performance; and 'heroizing' and lionization, which is favorably created by the public and/or media, may be deleterious.

Airplane Hijacking Passengers/Families

Thompson (1991) examined the psychological reactions of 13 survivors of an airplane hijacking in Kuwait. Although eight survivors showed probable psychological distress, in three of them distress was severe. The most common complaints were anxiety and intrusive memories, and to a lesser extent an inability to function properly at home and at work. At a follow-up 6 months later, four of them were above the cutoff point for psychological distress. The author outlined stages of responses to hijacking and their subsequent release.

In a more large-scale airplane hijacking study, Smith, Kilpatrick, Falsetti, and Best (2002) presented the findings of family members of the Pan Am 103 bombing above Lockerbie, Scotland. Participants were the surviving family members, interviewed twice using telephone interviews—once prior to completion of the criminal trial and again 7 weeks

after the verdict. Results indicated that many surviving family members suffered from considerable problems associated with the loss of their loved ones. Although the families found certain services provided by the United States Office for Victims of Crime helpful, they made specific recommendations for greater emotional support.

Body Handlers

Numerous studies have indicated that mortuary workers, body handlers, and those who work with human remains are at risk for symptoms related to posttraumatic stress disorder and other psychological sequelae. Peterson, Nicolas, McGraw, Englert, and Blackman (2002) described a method of psychological intervention with mortuary workers who were mobilized as a result of the September 11 attack on the Pentagon. The intervention was based on a model of incorporated knowledge from previous studies on mortuary workers and individuals tasked to work with human remains. Qualitative analysis indicated that the behavioral health consultants were well received, recommendations were implemented, and few personnel were removed from duty as a result of psychological factors leading to impaired performance.

In Israel, Solomon and Berger (2005) assessed the psychological consequences of body handling in the aftermath of terrorist attacks. Eighty-seven ZAKA (an acronym in Hebrew for ‘Identification of Victims of Disaster’) volunteers reported a low sense of danger and considerable self-efficacy. Only two participants met criteria for PTSD, while 16 met criteria for sub-clinical posttraumatic disorder. The authors posited that the resilience of the subjects was related to altruism, religious rewards, and respect and admiration from their society.

Flight Attendants

It is argued that a psychological contagion effect occurred in this at-risk group of workers. Lating, Sherman, Lowry, Everly, and Peragine (2004) compared psychological reactions and functional coping of East Coast and West Coast-based flight attendants after the September 11 attacks. Of the 2,050 returned surveys the East Coast members were more than twice as likely to know someone who perished in the wake of September 11, yet there was no difference between the East Coat and West Coast regarding probable PTSD (19.1% and 18.3%, respectively) or life functioning.

Gay/Lesbians

Shernoff (2002) noted that the terrorist attacks of September 11 have had a profound specific impact on the gay and lesbian population. This article reported on professionals' responses immediately following the disaster, and illustrates a variety of ways those events particularly affect gay men and lesbian women psychologically.

Inpatients

The September 11 attacks led to speculation about the particular vulnerability of psychiatric patients to psychological distress following such events. Taylor and Jenkins (2004) investigated the psychological impact of the media coverage of the September 11 events on Australian hospital psychiatric inpatients and medical patients. Results indicated that both experienced distress. Women reported significantly more distress than men. Individuals with psychiatric illness were significantly more varied in their attribution of the cause of the distress to September 11. Seven patients (29%) with pre-existing psychosis became delusional surrounding the events. Hospital inpatients were adversely affected by TV footage of the September 11 attacks, the most vulnerable being those already with a mental disorder, particularly those with a pre-existing psychotic illness.

More evidence about the unique risk of psychiatric patients was reported in a psychiatric population not directly impacted by the September 11 attacks. Franklin, Young, and Zimmerman (2002) examined the impact of the terrorist attacks on 308 psychiatric and medical outpatients living approximately 150 to 200 miles from the attack site. Findings indicated that psychiatric patients were significantly more likely than medical patients to report distressing symptoms meeting criteria for PTSD, despite no differences in learning about the attacks or personal involvement with the victims, and that patients meeting PTSD criteria were more likely to schedule an appointment with their physician about their reactions.

Military

Ritchie and Owens (2004) reviewed “some of the lessons in trauma psychiatry learned by the United States military through wartime and other trauma experiences during the past century” (p. 559). The military has ‘stress control teams’ to prevent and limit psychological casualties, and in order to guide the military's approach to managing the psychological aftermath of trauma. In fact, after September 11, guidelines were developed, and presented in a "Mass Violence and Early Intervention" conference.

Hoge, Pavlin, and Milliken (2002) conducted behavioral health surveillance among military health system beneficiaries in the Washington, D.C. area after the September 11 attack on the Pentagon. They found that although there was no significant increase in the total number of visits to behavioral health clinics, there were significant increases in the number of visits for anxiety disorder and acute stress reactions in children and for adjustment reactions in adults.

Grieger and Lyszczarz (2002) discussed the deployment and experiences of the Navy Special Psychiatric Rapid Intervention Teams (SPRINT) in response to September 11. SPRINT is a multidisciplinary team, including psychiatrists, psychologists, social workers, psychiatric nurses, and enlisted psychiatric technicians. During the 2 weeks following the attack, the team ran between 4 and 10 debriefings per day, involving 1-3 team members and 3-30 participants. Despite the short duration of the attack and the relatively limited loss of life of Navy personnel, there were significant psychological symptoms among the survivors during the first few days. "The wartime operational tempo made access to the survivors difficult and without command support, survivors were focused on the mission at the expense of their own well-being. Fostering group self-reliance and natural supports were primary tools in the mental health response. Although there will be some who have persisting and late onset symptoms, resilience was prominent; the team was able to stand down after 2 weeks with ongoing care provided by routine clinic appointments" (p. 24).

Pentagon/Department of Defense

Milliken, Leavitt, Murdock, Orman, Ritchie, and Hoge (2002) discussed "the implementation and planning of Operation Solace, a post-September 11 plan directed by the Army Surgeon General to proactively address the predictable behavioral health distress/disorders and related somatic phenomena expected to occur among the Pentagon employees, family members, and Department of Defense beneficiaries located in the National Capitol Region affected by the terrorist attack" (p. 48). According to the authors, the lessons learned include the need to: (a) retain a preventive, preclinical, population-informed approach; (b) intervene by preventing acute and/or chronic behavioral health

problems; (c) consult with leaders; (d) enhance group cohesiveness; and (e) make good contacts with everyone.

As part of a comprehensive family support program provided by the Pentagon Family Assistance Center, Howie, Burch, Conrad, and Shambaugh (2002) discussed art therapy interventions for children and their families in the aftermath of the Pentagon attack on September 11. Their paper described their therapeutic intervention and included information on the theoretical basis for the use of art therapy with victims of trauma.

Primary Care Physicians

Eisenman, Stein, Tanielian, and Pincus (2005) examined primary care physicians' roles in helping the American nation prepare for, respond to, and recover from the psychological consequences of terrorism. The authors discussed the psychological consequences of terrorism, and the specific roles of primary care physicians in responding to these consequences. They analyzed these roles in light of the known barriers to delivering high-quality, primary care-based mental health care, and offered recommendations for mitigating these barriers. Their recommendations included: improved communication with mental health and information technology, and further training, education and research.

Psychologists

"Theory and research clearly indicate that therapists can be negatively impacted by their work with survivors of trauma" as stated by Eidelson, D'Alessio, and Eidelson (2003, p. 144)—in the form of secondary or vicarious traumatization. These authors focused their research on mental health caregivers' experience of terrorist acts on. Overall, practitioners described significant changes in both their professional work and their personal lives, with those respondents working closest to 'ground zero' reporting the greatest changes. Proximity

to ‘ground zero’ was at least somewhat related to increased stress, feeling unprepared, and, in addition, positive feelings! The sample reported more positive than negative feelings regarding their work in the post-September 11 environment. Although the survey return rate was only 15%, the authors interpreted the findings to shed light on several important professional issues related to disaster relief, including service utilization, preparedness, and vicarious traumatization.

Teachers

Pfefferbaum, Pfefferbaum, Gurwitch, Doughty, Pynoos, Foy et al. (2004) assessed teachers' reactions to the Oklahoma City Bombing. Results showed that stress from media coverage, peritraumatic reactions, subjective feelings toward the perpetrators, and worry about safety predicted posttraumatic stress. In addition, twenty percent reported difficulty handling demands, while 5% sought counseling. Female teachers reported more peritraumatic reactions and higher posttraumatic stress than did male teachers.

Non-US Regions

Algeria

Khaled (2004) stated that “since 1990, Algerians have suffered from the effects of radical Islamist terrorism. The official estimate of 150,000 massacred terrorism victims seems low and includes only direct victims. Epidemiological research conducted in 1999-2000 found that the Algerian population has suffered enormously” (p. 201). The author conducted a study of a random sample of the adults, of which 91 percent were victims of a traumatic event; of those, 39 percent suffered from posttraumatic stress disorder, 23 percent from a mood disorder (depression), 38 percent from an anxiety disorder (e.g., panic disorder

or phobia), and 8 percent from somatoform disorder. With such staggering findings, the author concluded that healing would necessitate a concerted, collaborative effort.

Canada

Davis and Macdonald (2004) surveyed 80 Canadian adults' reactions to the US terrorist attacks of September 11. Results indicated that greater perceived threat and greater initial distress reactions predicted the extent to which people reported positive changes in their lives (e.g., closer familial relationships, refocused priorities). Initial distress and greater perceived threat also correlated positively with acts of altruism post-disaster. Follow-up data on 40 of these participants, approximately 1 year later, revealed significant stability over time for the extent of positive life changes reported, and demonstrated that the degree of initial distress and perceived threat continued to correlate positively with life change reports at this later point in time. These data are consistent with the argument that the perception of growth may develop out of one's personal experience of emotional pain, and with the speculation and documentation that the terrorist attacks led many people to make positive changes in their relationships, values and priorities.

France

Verger, Dab, Lamping, Loze, Deschaseaux Voinet et al. (2004) conducted follow-up evaluations with the victims of a wave of bombings in France, in 1995 and 1996, killing 12 people and injuring more than 200. Victims directly exposed to the bombings (sample size of 228) were recruited into a retrospective, cross-sectional study, to evaluate PTSD and to assess health status before the attack; initial injury severity and perceived threat at the time of attack; and psychological symptoms. Results, from a total of 196 respondents, showed that 19% had severe initial physical injuries (hospitalization exceeding 1 week), while 31% met

criteria for PTSD. PTSD was significantly higher among women participants (age 35-54), and those who had severe initial injuries or cosmetic impairment, or those who perceived substantial threat during the attack. The authors concluded that the high prevalence of PTSD, 2.6 years on average after a terrorist attack, emphasizes the need to address the intermediate and long-term consequences of terrorism.

Israel

In relation to the September 11 attacks, Somer, Ruvio, Soref, and Sever (2005) noted that "although the nature of this isolated, sudden and astounding event is qualitatively different from the repeated chronic terrorism Israelis have been subjected to, recently published data about the aftermath of that attack shed light on the impact of terrorism worldwide" (p. 165).

Shalev, Schreiber, and Galai (1993) followed 16 injured survivors of a terrorist act, ranging in ages from 20-65 years, who were hospitalized in a large medical center. The subjects experienced rapidly changing mental status, with intrusive recollections of the event, yet with varying degrees and arousal. Early interventions were aimed at increasing their sense of self-control and mastery over secondary stressors.

In yet another study, 260 young terror victims were evaluated in the Emergency Room of a general hospital immediately after several terrorist attacks in Jerusalem. Galili, Weisstub, and Benarroch (2004) presented a developmental perspective, through descriptions of the psychological manifestations in different age cohorts. Surprisingly, results showed that less than 20% of the victims presented with a pathological acute stress reaction.

Madrid

Iruarrizaga, Miguel Tobal, Cano Vindel, and Gonzalez Ordi (2004) explored the psychological aftermath in victims, and their relatives, directly exposed to the Madrid March 11, 2004 terrorist attack. The sample consisted of 117 adults, with a mean age of 39.8 years, and was comprised of 59.5% females. In the 1- and 3- month intervals after the terrorist attack, the sampled populations presented with higher psychopathology than the general population in affected zones and emergency personnel. Almost half of the sample suffered panic attacks during or soon after the terrorist attacks, 31.3% presented with major depression, and the 35.9% presented with posttraumatic stress disorder; additional psychological sequelae included an increase in tobacco, alcohol and drug use.

Miguel Tobal, Cano Vindel, Iruarrizaga, Gonzalez, and Galea (2004) performed three longitudinal studies with the aim of assessing the psychological impact of the March 11 bombings on the Madrid city population, focusing on: (1) the general population, (2) the victims and their relatives, and (3) the emergency personnel and rescue workers. Assessing a representative sample of Madrid city residents, consisting of 1,589 subjects, the authors employed a methodology similar to Galea et al. (2002) in their study of the September 11 terrorist attacks in NYC. Findings regarding psychological symptoms were: 10.9% experienced panic attacks, 8% experienced major depression, and 4% met criteria for PTSD.

Munoz, Crespo, Perez Santos, and Vazquez (2004) reported on the results of a study done after the terrorist attack in Madrid on March 11. The sample data was examined to adjust age and sex to the Madrid population distribution. The research found that, in the second week post-event, 49.6% of the sample presented with symptoms of depression. Of these, 17.1% displayed functional deterioration. Also, 46.7% showed symptoms of acute stress, in which 16.8% exhibited functional impairment. In 13.5% of the sample, symptoms

of depression and acute stress appeared simultaneously and were accompanied by functional impairment. The most frequent symptoms of acute stress reported were the re-experiencing of the event and disassociation.

Moscow

Speckhard, Tarabrina, Krasnov, and Mufel (2005) reported on interviews with hostages from the October, 2002 hostage-taking event in a Moscow theater. All participants displayed significant posttraumatic stress responses, in addition to Stockholm Syndrome. (Stockholm Syndrome was first reported, following a bank robbery in Stockholm. This syndrome is characterized by hostages developing a bonding to their captors. Believed to be an automatic unconscious defense which arises during traumatic experiences, the attachment which is fostered between the hostages and their captors allows the victims to identify with the aggressor, thereby enhancing coping and instilling optimism, while being held under siege.) It is important to note that this syndrome "has never been tested in a naturalistic event" (Speckhard et al., 2005, p. 131).

Nairobi, Kenya

Thielman (2004) noted that the August 7, 1998 bombing of the American embassy in Nairobi affected a large number of people, both Kenyan and American. The bombing led to a large-scale response from the Kenyan mental health community and to collaboration between American and Kenyan responders. Kenyans affected by the bombing frequently expressed their psychological distress in terms of somatic complaints.

Njenga, Nicholls, Nyamai, Kigamwa, and Davidson, J. R.T. (2004) described the reactions, features of, and risk factors for posttraumatic stress symptoms of a large, non-Western sample after the attack on the US embassy bombing in Nairobi. A self-report

questionnaire which assessed potential risk factors and identified symptoms of criteria for posttraumatic stress disorder was answered by 2883 Kenyans, 1 to 3 months after the bombing. Results showed that symptoms approximating to the criteria for posttraumatic stress disorder occurred in 35%. Factors associated with posttraumatic stress included female gender, unmarried status, lack of college education, witnessing the event, injury, not recovering from injury, not confiding in a friend, bereavement, and financial difficulty since the bombing.

Omagh, Ireland

McDermott, Duffy, and McGuiness (2004) explained that after the terrorist attack in Omagh, Northern Ireland, in 1988, a Community Trauma and Recovery Team was established and was operational for approximately three years. According to the authors' statistics, during this period, there were 130 (83 female, 47 male) referrals of children and young people, mostly within the first year. The major diagnostic category was that of posttraumatic stress disorder, followed by depression and anxiety, although some had more than one diagnosis. Parents were also seen to provide support and advice regarding management of trauma-related symptoms.

Other Geographic Regions

The following is an alphabetical listing, by first other, of works with emphasis on other particular geographic regions: Abu Saba, 1999; Baldomero and Arrate, 1997; Cairns & Lewis, 1999; Goodwin, Willson, and Gaines, 2005; Hollander, 1992, 1997; Irwing and Stringer, 2000; Lewis, 2004; Levine, 1996; Miller, 1996; Sharkey, 1997; Simpson, 1998; Tucker, Pfefferbaum, Doughty, Jones, Jordan et al., 2002; and Tucker, Pfefferbaum, Nixon, & Dickson, 2000.

US Region

NYC population

NYC children and adolescents.

Aber, Gershoff, Ware, and Kotler (2004) conducted a longitudinal study which examined the effects of exposure to the terrorist attack of September 11, as well as exposure to other forms of community violence, on change in the mental health and social attitudes of New York City youth (middle childhood ages). The design of this study distinguished among direct exposure, indirect exposure, and family exposure, as the youth of New York City experienced varying degrees of exposure to September 11. According to the authors, three quarters of the youths reported some form of direct exposure, and 80% reported exposure to at least 1 form of media coverage. These rates were comparable with the survey of public school students in New York City, conducted by the New York City Department of Education. Results indicated that direct exposure and family exposure did not predict change in mental health outcomes, but did predict change in levels of social mistrust; media exposure did predict posttraumatic stress disorder symptoms. The authors concluded that not only are mental health problems likely to arise, but so are also changes in social attitudes and social cognitive processes.

Balas and Guttman (2003) conducted a qualitative study among child analytic colleagues, mostly from the New York Psychoanalytic Institute, to determine the psychological impact of the World Trade Center disaster on children. The authors noted the psychoanalytic factors which may account for individual differential responses, including level of cognitive development, specific developmental stage-related conscious and

unconscious fantasies and conflicts, ego strength, defensive style, and character of both the parents and the child, as well as past traumatic experiences.

Wilson and Rosenthal (2004) tested a model that has emerged from previous research on disasters, using a sample of 711 first year college-students who had attended high school in New York City at the time of September 11 attacks. Retrospective and prospective reports of acute distress at 2, 6, and 13 months after the attack were assessed. The model tested suggests that postdisaster psychological distress is a function of exposure to the disaster, predisaster psychological distress, acute distress following the disaster, time elapsed between disaster and observation of distress, and additional traumatic experiences since the disaster. Although findings of this study replicate those of previous cross-sectional studies regarding association of exposure and distress after the disaster, the before and after studies did not detect an effect on postdisaster psychological distress. As such, the authors cautioned against attributing elevated psychological distress which is observed postdisaster to the effects of the disaster.

Malin and Fowers (2004) examined the emotional response of 110 adolescents living in the New York metropolitan area one month and five months after the destruction of the World Trade Center by the terrorists. The purpose of the study was to assess emerging hypotheses in political psychology that suggest that there are differential emotional responses to a national trauma that recede in predictable directions. The results corroborated that adolescents experienced a higher level of emotions related to the crisis and bereavement dimension than affect associated with vulnerability, and that the emotional response decreased during the four-month follow-up period. There was no effect on emotional

response from the gender or the political orientation of the respondents, which is inconsistent with other studies in the literature.

NYC adults.

Galea, Ahern, Resnick, Kilpatric, Bucavalas, Gold, et al. (2002) assessed the prevalence and correlates of acute posttraumatic stress disorder and depression among Manhattan residents during the 5-8 weeks after the September 11. Using a representative sample of adults living south of 110th Street, the authors explored demographic characteristics, the type and level of exposure to the events of September 11, and the psychological symptoms after the attacks. Among 1008 adults interviewed (with a mean age 42 yrs), 7.5% met criteria for PTSD related to the attacks, and 9.7% reported symptoms consistent with depression. Among those respondents who lived south of Canal Street (i.e., near the World Trade Center), the prevalence of PTSD was 20%. Predictors of PTSD, per the author's statistical analyses, were: Hispanic ethnicity, 2 or more prior stressors, a panic attack during or shortly after the events, residence south of Canal Street, and loss of possessions due to the events. Predictors of depression were: Hispanic ethnicity, 2 or more prior stressors, a panic attack, a low level of social support, the death of a friend or relative during the attacks, and loss of a job due to the attacks. It is important to note that this particular study is widely cited—and even replicated (Cano Vindel, Miguel Tobal, Gonzalez Ordi, & Iruarrizaga, et al., 2004) in the literature—not only because of its findings, but also because of its sound methodology.

Chen, Chung, Chen, Fang, & Chen (2003) examined the psychological impact of the September 11 disaster on the immediate neighborhood of the New York World Trade Center, among 555 residents of the local Chinatown community. Anxiety was found in the general

community residents, and depression in those who lost family members or friends. The mental health condition of the community improved tremendously 5 months after the attacks, with the initial 59% of general residents reporting 4 or more emotional symptoms reduced to 17%. However, more than half of the community residents had persistently shown one or more symptoms of emotional distress. Results indicated that those who had lost a family member or friend experienced significantly higher distress. Overall, participants in their 40s and 50s seemed to have had relatively higher emotional distress than both younger and older cohorts.

NYC older adults.

Elderly Hispanics are a particularly vulnerable age cohort, in terms of both age and ethnicity, given that they constitute the fastest growing subpopulation among the aged. Strug, Mason, and Heller (2003) conducted an exploratory, qualitative investigation of the impact of the year of September 11 on older Hispanic immigrants in New York City. Six focus groups, with a total of 31 participants, yielded reports on the psychological reactions to the traumatic events of September 11 and the crash of Flight 587. Four months after the attacks, most subjects had recovered from their acute distress reactions, but many still experienced a wide range of psychological reactions related to these traumatic events, including anxiety, avoidance, and hypervigilance.

Brennan, Horowitz, and Reinhardt (2003) assessed the post September11 depressive symptomology of older adults with vision loss in New York City. More specifically, the research compared 2 months' pre-September 11 depressive symptoms with those of 2 months post-attack. Findings do not reflect significant biasing effects of September 11, nor were there any interaction effects of the event with age, gender or education. The authors attribute

these results, in part, to the resiliency of older adults who have coped with other stressful events in their lifetime.

NYC women.

Pulcino, Galea, Ahern, Resnick, Foley, and Vlahov (2003) determined that women in New York City were more likely than men to have probable posttraumatic stress disorder 5-8 weeks after the September 11 terrorist attacks. The authors explored the factors that could explain the higher prevalence of probable PTSD among women in the aftermath of the attacks through a telephone survey of a randomly selected group of residents of Manhattan living south of 110th street. Among 988 respondents, women were two times more likely than men to report symptoms consistent with probable PTSD. The results suggest that specific behavioral and biographic factors (including previous traumatic experiences and psychological disorders, social responsibilities, and pre-event emotional reactions) explained the higher probability of women to experience PTSD after a disaster.

NYPD.

Irvine (2005) conducted interviews with police officers who had been at the World Trade Center site when the buildings collapsed, eliciting detailed accounts of their experiences on that day. Phenomenological analyses of these interviews revealed significant existential meanings attributed to their experiences. The results reveal that the officers identified strongly with their roles as NYPD officers; they were dedicated to protect and serve the public; and they held saving lives as their highest value. Because of this, the officers were especially distressed when they witnessed the demise of those who jumped to their deaths from the burning towers, or who were killed on the ground, and they felt stripped of their confidence and power. Yet, they were able to maintain a continuity of experience by

participating in a community of shared humanity. The officers coped with their own survival by maintaining the value of being of service to others, and by upholding the belief that those whom they saved would go on to save the lives of others.

National Samples

Children.

Pfefferbaum, DeVoe, Stuber, Schiff, Klein and Fairbrother (2004) reviewed the literature on the psychological impact of terrorism on children and families in the United States, including studies of the 1993 World Trade Center bombing in New York City and the 1995 Oklahoma City bombing, as well as the September 11 attacks. These studies explore the impact of various forms and degrees of exposure to terrorism on children across the development spectrum and on the relationships between parental and child reactions. The article concluded with a framework for future research on children's adaptation following mass trauma, noting that children who are both directly and indirectly exposed to terrorist attacks are particularly vulnerable to adverse emotional sequelae.

Adolescents.

Gil Rivas, Holman, and Silver (2004) assessed the event-related acute stress symptoms of adolescents from a national sample, approximately 2 weeks after the September 11 attacks. In addition, one year later, these adolescents and a randomly selected parent from their household completed were assessed again. Results show that, on average, adolescents reported mild to moderate acute stress symptoms after the attacks and few trauma-related

symptoms, and low psychological distress and functional impairment. Moreover, findings indicated that greater parent-adolescent conflict was associated with the adolescents' trauma symptoms, distress, and functional impairment.

Adults.

Phillips, Featherman, and Liu (2004) conducted a longitudinal study involving parents' and other adults' own psychological vulnerability, as well as any observed reactions of co-residents and other children. Immediately after September 11, they sampled 752 participants; one year later they sampled 484 participants. Findings showed that for a significant minority of adults, perceived threat from the terrorist attacks was both elevated and sustained. More specifically, single mothers and others living with children, non-Black Hispanics, and those reporting depressed mood immediately after September 11 were each significantly more vulnerable to feeling threatened than other adults. Also, adults and/or parents who encountered children who they perceived to be fearful and upset following the attacks were significantly more likely than those not encountering distressed children to experience disrupted feelings of safety and security both immediately, and 1 year after, the September 11 attacks. The authors highlighted the significance of bi-directional processes in parent-child relationships, as it pertains to psychological adjustment.

Another study described the application of a relatively new methodology—computerized text analysis—to the recent cultural phenomenon of public on-line diaries, as they reflected responses to the overwhelming personal and cultural upheaval of September 11. Cohn, Mehl, and Pennebaker (2004) analyzed the diaries of 1,084 U.S. users of an on-line journaling service. These diaries were downloaded for a period of 4 months spanning the 2 months prior to- and after- September 11. Linguistic analyses of the journal entries

revealed more negative emotions, more cognitive and social engagements, and greater psychological distance. Yet, after 2 weeks, the diary writers' moods and social referencing returned to baseline, and their use of cognitive-analytic words dropped below baseline. Over the next 6 weeks, social referencing decreased and psychological distancing remained elevated relative to baseline. The authors noted that although the effects were generally stronger for individuals highly preoccupied with September 11, even participants who hardly wrote about the events displayed similar linguistic changes.

Richman, Wislar, Flaherty, Fendrich, and Rospenda (2004) found that women experiencing chronic work stressors were most vulnerable to elevated psychological distress and alcohol use after September 11. The research used mail surveys to assess decision latitude, sexual harassment, generalized workplace abuse, psychological distress, and alcohol use before and after September 11.

Stein, Elliott, Jaycox, Collins, Berry, Klein et al., (2004) also found elevated distress levels among adults. In their re-sampling of participants from an earlier study, 395 adults with persistent distress reported accomplishing less at work (65%); avoiding public gathering places (24%); and using alcohol, medications, or other drugs to relax, sleep, or feel better (38%). In terms of coping mechanisms, seventy-five percent talked with family and friends; however, 43% reported sometimes feeling unable to share their terrorism-related thoughts and feelings. Interestingly, only 11% reported receiving counseling or information about psychological distress. The authors contended that these findings suggest that a significant number of adults across the country continued to experience terrorism-related distress and disruption of their daily lives approximately 2 months after September 11. Also, while family

and friends were a source of support, few clinicians were utilized to alleviate distress symptoms.

Silver, Holman, McIntosh, Poulin, and Gil Rivas (2002) sampled 2,729 adults across the country between 9 and 23 days after the September 11 terrorist attacks, using a web-based survey. A random sample of 1,069 participants residing outside New York, NY was drawn from the initial sample, and received a second survey. A total of 933 (87% participation rate) completed it approximately 2 months following the attacks, and 787 participants completed it approximately 6 months after the attacks. Findings were revealing regarding the degree to which demographic factors, mental and physical health history, lifetime exposure to stressful events, September 11-related experiences, and coping strategies used shortly after the attacks predicted psychological outcomes (acute stress, posttraumatic stress, and global distress). The authors found that, 2 months after the attacks, 17% of the US population outside of New York City reported symptoms of September 11-related posttraumatic stress, while 5.8% did so 6 months after the attacks. High levels of posttraumatic stress symptoms were associated with female gender; marital separation; pre-September 11 depression or anxiety disorder, or physical illness; severity of exposure to the attacks; and early disengagement from coping efforts.

Schlenger (2004) surveyed the findings of major studies of the September 11 terrorist attacks, noting that empirical documentation of psychosocial distress became available quickly after the September 11 attacks. In summarizing the findings, the authors explained that although Americans experienced distress from the attacks, much of the documented distress was not clinically significant and subsided relatively quickly, without intervention. Of those who did experience clinically significant symptoms, most were residing in New

York, and their symptoms are likely to be chronic and thus require a shift in intervention, namely from ‘returning to normal’ to ‘adapting to a new reality.’

Oklahoma City Bombing

Sprang (2001) explored the intermediate psychological effects of the Oklahoma City Bombing on adults who were not directly affected by this terrorist act. The authors examined the course of posttraumatic stress disorder and sub-threshold PTSD symptoms over time and whether treatment affected this course. Forty-four respondents (with a mean age 34.8 years) were interviewed at 3-month intervals, for 18 months following an initial 6-month survey. Analysis suggested that avoidance, re-experiencing, and increased arousal symptoms in this population were limited over time, declining with or without treatment between 6 and 9 months. Conversely, victimization symptoms remained high without mental health intervention for the 1st year after the disaster.

In contrast, Benight, Freyaldenhoven, Hughes, Ruiz, Zoschke, and Lovallo (2000) studied the psychological effects of terrorism on adults who *were directly* affected by the Oklahoma City bombing. Findings from a study of 27 victims (with a mean age 41 years) supported the authors’ hypothesis that assessments of coping self-efficacy taken 2 months after the bombing added significantly to the explanation of general and trauma-related distress, after controlling for income, social support, threat of death, and loss of resources. Coping self-efficacy measures performed 1 year later were also important in explaining psychological distress after controlling for loss of resources and social-support perceptions. Although coping self-efficacy perceptions taken at 2 months were related to distress levels 1 year later, they did not remain significant after controlling for loss of resources and income.

Conclusion

In sum, a review of the literature by populations yields predisposing factors that have been found to predict adverse impact and/or delayed recovery from trauma. These are: gender, ethnicity, and premorbid differentials in depressed mood. Although gender-differences are not consistently supported by the research, women are more likely to disclose greater distress than men; minorities—specifically African Americans and Hispanics—report greater adverse reactions and delayed recovery. Also, the literature shows that the degree of access to social support, in addition to relief from other unrelated stressors, are both predictors in post-disaster functioning.

Level of Exposure to the Act of Terrorism

While a great deal of the literature focused on the psychological effects of direct exposure to terrorism, as noted in the previous portion of this chapter, there has also been recent emphasis (Cano Vindel, et al., 2004) on the indirect exposure, and its psychologically traumatic implications (Pine, Costello, & Masten, 2005). In the following studies, researchers delineate some of the well-known negative effects of what is known in the literature as indirect exposure, or vicarious traumatic exposure (Linley, Joseph, Cooper, Harris, & Meyer, 2003).

Somer et al., (2005) assessed the level of exposure to terrorism for individuals residing in the affected areas. A random sample of 327 Israeli adults, purposely over-sampled from the hardest-hit areas, was surveyed. Findings did show that those residing in the most severely hit locales were also those who suffered most from posttraumatic symptoms, yet the effects were not limited to those directly exposed to it. As such, the authors concluded that objective measures of exposure or loss may not be sensitive enough to predict reactive distress.

Schuster, Stein, Jaycox, Collins, Marshall, Elliot, et al., (2001) assessed the immediate mental health effects of September 11 with a nationally representative sample of 560 adults. They found that participants throughout the country reported substantial symptoms of stress. The authors concluded that clinicians who practice in regions that are located far from terrorist attacks should be prepared to assist people with trauma-related symptoms.

Schlenger, Caddell, Ebert, Jordan, Rourke, Wilson et al. (2002) also assessed psychological symptom levels in the US following the events of September 11, at 1- and 2-months after the attacks. Participants were 2,273 adults—including oversamples of the New York City, and Washington, DC metropolitan areas—who reported symptoms of PTSD and/or nonspecific psychological distress. Findings indicated that the prevalence of probable PTSD was significantly higher in the New York City area in Washington, DC, than the rest of the country. Gender, age, direct exposure to the attacks, and the amount of time spent viewing TV coverage of the attacks on September 11 were associated with PTSD symptom levels; gender, the number of hours of TV coverage viewed, and the content of that coverage were associated with nonspecific psychological distress.

Cano Vindel et al. (2004) explored how exposure to the Madrid March 11, 2004 terrorist attack impacted residents of Spain. The study examined the differences between the general population of residents in the city of Madrid and people living in three areas within a radius of 1km around the explosions. The methodology was similar to that used by Galea et al. (2002) in the research study of the September 11 terrorist attacks in New York City. The findings of the Madrid study were consistent with the findings of the NYC research:

proximity to the terrorist attack venue did have a significant impact on the psychological sequelae related to the attacks.

Yet, in another study of over 1,900 adults at 2 weeks and 12 months post-September 11, the effects of the attacks were not limited to those communities who were directly affected by the attacks. Silver, Poulin, Holman, McIntosh, Gil Rivas, and Pizarro (2004) state that "instead, our data show that substantial effects of September 11th rippled throughout the country. Posttraumatic stress symptoms clearly declined over the first year post-9/11. Nonetheless, many individuals who were not directly exposed to the attacks reported symptoms both acutely and over the year afterwards at levels that were comparable to those individuals who experienced the attacks proximally and directly" (p. 138). In fact, "many individuals who lived hundreds of miles from the attacks or had low levels of exposure (i.e., individuals who watched the attacks live on TV and those who reported no direct exposure at all) reported high levels of symptomatology. In addition, there was great variability in acute and posttraumatic response among individuals who observed the attacks directly or lived within the directly affected community" (p. 139). Consistent with some of the literature, the authors contended that there are many and various psychological and behavioral consequences of trauma "including generalized distress, intrusive ruminations, physical symptoms, increased health care utilization, disruptions in functioning, decreased subjective well-being, meaning-making, construal of personal benefits, and positive community effects" (p. 131).

Two studies examined the adolescent response to exposure to terrorist attacks. Ronen, Rahav, and Appel (2003) studied two groups of Israeli Jewish adolescents who evidenced similar levels of both emotional and geographical proximity to a terrorist attack in Tel Aviv:

(a) local Tel Aviv youth, for whom the attack constituted a single, isolated, acute stressor, and (b) youth from a border settlement, for whom this attack constituted one event in a continuous series of terrorist incidents. Results showed significant differences in each group's increase in fears pre-event to the post-event. The Tel Aviv group reported a higher increase in fears than the border settlement group. In addition, those who personally knew a victim or were physically close to the terrorist attack reported more fears and symptoms than those who did not know a victim personally, or were physically more distant from the attack venue. Moreover, proximity did affect the single incident (Tel Aviv) group but did not affect the continuous incident one (border settlement).

Barnes, Treiber, and Ludwig (2005) examined the impact of exposure to September11 on physical and emotional stress-related responses in African-American adolescents living in Georgia. Three months after the attacks, 406 participants were evaluated to measure loss of psychosocial resources (i.e., control, hope, optimism, and perceived support) and posttraumatic stress symptomatology. Results indicated that 10% of the sample was experiencing probable clinically significant levels of posttraumatic distress. The authors concluded that the majority of the adolescents were not overly stressed by indirect exposure to the events of September 11, and they attributed these finding to the temporal, social, and/or geographical distance from the event.

Conclusion

It appears that the empirical literature regarding the level of exposure to terrorist attacks is somewhat inconclusive. In reference to this, Silver et al. (2004) propose three myths to consider: "one myth is that the psychological responses to traumatic events are predictable: that is, that there are universal reactions to traumatic events. A second myth is

that psychological response to traumatic events will follow a pattern, or [an] orderly sequence of stages. A third myth is that psychological response to trauma requires direct, proximal exposure to the stressor, and that traumatic stress response is proportional to the degree of exposure, amount of loss, or proximity to the trauma (i.e., as 'objective' loss increases, so will its impact)" (p. 131). Danieli et al. (2005) added further commentary, stating that "while post-9/11 surveys suggest that direct exposure to an attack is closely related to PTSD symptoms in adults, it is not related to non-specific distress, most of which is transient and self-limiting" (p. 777). Moreover, as the paper stated, clearer definitions of exposure are needed.

CHAPTER IV

SALIENT THEMES IN THE LITERATURE

Resilience

Perhaps surprisingly, *positive* effects were found to be correlated with exposure to terrorism. However, less is known about potential positive changes than is known about the negative effects (Linley et al., 2003). As pointed out by Bonanno, Rennicke, and Dekel (2005), "much of the preliminary research on the September 11th attack has focused on posttraumatic stress disorder . . . . By contrast, relatively little research has focused on the opposite extreme: individuals who were directly exposed to the attacks but nonetheless evidenced psychological resilience" (p. 984).

Most of the literature on the positive effects, correlations, or implications of terrorism has been clustered within the construct of *resilience* (Reissman, Klomp, Kent, & Pfefferbaum, 2004). Danieli et al. (2005) contend that many articles consider resilience—both on the individual and community level—as "an important psychosocial protective factor in the struggle against the consequences of terrorism in particular and trauma exposure in general" (p. 783).

Resilience is defined by Newman (2005) as "a multidimensional and not a unitary concept. There is no one characteristic or trait identified as resilience. Rather, there are many behaviors and actions associated with resilience. Maintaining good relationships, having an optimistic view of the world, keeping things in perspective, setting goals and taking steps to reach them, and being self-confident, for example, are all associated with resilience" (p. 227). Yet, "one individual's strategy for building resilience will likely not be the same as another's [as it is] an individualized process dependent, in part, on each individual's strengths, skills,

and experience. . . . Moreover, it is not so easily accomplished by people who have specific psychological disorders" (p. 227). Resilience is best understood as "one end of a continuum of vulnerability to emotional dysfunction and psychopathology when exposed to a stressful experience. Thus an individual at the extremely vulnerable end of the continuum may experience great distress . . . . while a person at the resilient end would require a great deal of stress to cause significant impairment in functioning" (Foa, Cahill, Boscarino, Hobfoll, Lahad, McNally et al., 2005, p. 1808).

A complex psychological construct, resilience is associated with many beneficial outcomes—including stress reduction, stress prevention, improved physical health, and longevity, to name a few (Bonanno et al., 2005)—in addition to its correlation with enhanced coping in the wake of terrorist attacks. Fredrickson, Tugade, Waugh, and Larkin (2003) found that positive emotions, the ingredients of resilience, experienced in the aftermath of the September 11 attacks buffer resilient people against depression, and also promote blossoming. In a study of US college students, the positive emotions (e.g., gratitude, interest, love) fully accounted for the relationship between (a) pre-crisis resilience and later development of depressive symptoms, and (b) pre-crisis resilience and post-crisis growth in psychological resources.

Bonanno et al.'s (2005) findings echoed these conclusions. The authors examined self-enhancing bias, which is a characteristic of resilience—as a predictor of adjustment among individuals in or near the World Trade Center during September 11. Results indicated that self-enhancement was associated with a resilient outcome, better adjustment prior to September 11, and greater positive affect.

Finally, given the significant impact of resilience, the American Psychological Association (APA) created a ‘resilience initiative’ after the terrorist attacks of September 11. Data culled from focus groups conducted by the APA Practice Directorate indicated that people who were experiencing a chronic sense of stress and uncertainty desired to be more resilient. In response, APA launched a public education campaign, "The Road to Resilience"—a partnership with the Discovery Health TV Channel, which aired a documentary on resilience as a greater community outreach effort (Newman, 2005).

Parent-Child Dynamics

Another theme which was salient in the literature about the psychological impact of terrorist attacks on victims and the general civilian population was that of the dynamic between parents and their children. The parent-child interaction is deemed so pivotal in either facilitating or impeding coping, that the US Department of Education published a brochure providing suggestions for adults, as to how to help their children cope with the events of September 11. The brochure discusses the range of possible reactions of children, and ways to meet their needs for communication and understanding (US Dept of Education, 2002). In fact, (Schuster et al., 2001) found that following September 11, out of a nationally representative sample of 560 US parents, 84% reported that they or other adults in the household had talked to their children about the attacks for at least an hour; 34% restricted their children's television viewing. These statistics are not surprising, given that 35% of the children in these household displayed one or more stress symptoms.

Gil Rivas (2003) sought to further our understanding of the specific mechanisms through which parents can either facilitate or impede their children’s reactions to negative life events. The study examined the direct and moderating effects of (a) parental support, (b)

parental posttraumatic stress and nonspecific distress symptoms, (c) parental coping advice, and (d) perceived parental constraints in discussion regarding the September 11 terrorist attacks—against their adolescent children's posttraumatic stress and nonspecific distress symptoms. A sample of 104 parent-adolescent dyads from a national sample was surveyed at 2 weeks and 7 months post-September 11, to assess acute stress symptoms. Findings indicate that both parental distress and adolescents' perceptions of the availability of their parents for talking about their September 11-related concerns were associated with higher levels of posttraumatic symptoms among adolescents. Moreover, specific parental recommendations for coping strategies served both a facilitative and detrimental role in the psychological adjustment adolescents over time. In general, the author noted, the results of this study provided empirical support for the idea that parental symptomatology and parental behaviors play an important role in the adjustment of adolescents following a major negative life event.

Yet another study investigated the relationship between the parent-adolescent dyad and adjustment to trauma. Levine, Whalen, Henker, and Jamner (2005) examined changes over time in adolescents' and parents' memories of how they felt when they learned of the terrorist attacks on September 11. Adolescents recalled having felt less negative emotion than parents did, at both 3 months and 8 months after the September 11 attacks. While the intensity of recalled negative emotion decreased over time for adolescents, it increased for parents. Moreover, parental anxiety and stress at 3 months predicted adolescent reactions at 8 months. However, there was no evidence of bidirectional effects.

Political Psychology

Although community terrorism, by definition, is aimed essentially at a community, much of the psychological trauma-related published literature and research has focused on

the impact of terrorism on the individual psyche. Nonetheless, there is a small but growing volume of research which is focused on studying the psychological impact of terrorism on the community. Danieli et al. (2005) underscored the need for such studies: "the more that wars and terrorists target civilian populations, the more important it becomes to develop approaches that conceptualize the community as their focus. Such approaches do not neglect individuals in need, but view the coherence and well-functioning of the community not only as contributing to successful coping with trauma at the individual and societal levels, but also as a defense against terrorism" (p. 779).

A discipline which aims to integrate a cohesive community-based conceptualization in research is 'political psychology.' As explained by (Malin & Fowers, 2004):

> This field of research has grown out of the recognition of two biases in the traditional psychological and psychiatric literature. The first is that investigators focus too much on the individual and generally do not examine larger social events and trends. Second, the traditional studies only view trauma trough very narrow lenses, such as mental health, personality, and psycho-therapeutic intervention [as cited in] (Suedfeld, 1997). Political psychology seeks a broader approach that is not constrained by these limiting biases. One of the key concepts in the area of political psychology is trauma…. Almost all definitions of trauma in the context of political psychology recognize its accompaniment of intense emotions. The emotions surrounding trauma, both in political instances and in individual situations, can result in a variety of disorders among those who were exposed to trauma in any sort of way. . . . Political psychology research does not focus particularly on PTSD because the field emphasizes the general communal aspects of political trauma rather than the

extreme traumatization of particular individuals" (pp. 77-78). However, "political psychology research on responses to communal trauma is in its infancy, with a small number of studies examining widely different events (assassination and terror attacks) in countries with drastically different political and social ambiances (the United States and Israel)" As such, the authors note, "it is yet not clear how much similarity will emerge in citizens' responses to trauma with varying characteristics and in different countries" (p. 79).

Methodology Issues

Methodology problems, within the specific arena of the psychological consequences of terrorism, are abundant. The primary reason for the less-than-stellar methodologies, is the less-than-perfect 'testing conditions.' Terrorist acts, by definition, are unpredictable and are not announced by clear warning signs. Therefore, researchers can not plan to study specific events before they occur—if they ever do occur.

Other methodology shortcomings well-noted in the literature include: difficulty in identifying and accessing adequate control groups; the considerable amount of time which elapses between the terrorist act and the planning and execution of a study; and difficulties in sampling as a result of post-terrorism disruption and disorganization (Baum & Dougall, 2002).

In addition, interpretations of findings of post-terrorism distress may also be erroneous, since the experience of the terrorist-related trauma may not be causally linked with post-trauma distress. Wilson and Rosenthal (2004) explain that there is an "almost exclusive focus on rejecting the null hypothesis to establish a relationship between exposure to a disaster and postdisaster distress, without reporting an effect size for the relationship" (p.

590). They add that “we must recognize that there are, indeed, considerable amounts of psychological distress in populations who have recently experienced a disaster—but there are also similar amounts of psychological distress in populations who have *not* recently experienced a disaster” (p. 604).

Evidence-Based Interventions

Friedman, Foa, and Charney (2003) state that although “a wealth of information had been accumulating in recent years concerning the adaptive and pathologic responses to traumatic stress, only a handful of *rigorous* [emphasis added] studies have tested acute psychosocial and pharmacological interventions” (p. 765). As echoed by McCabe et al. (2004) “there is a dearth of randomized controlled trials (RTCs) in the literature of disaster mental health” (p. 200).

Not only are there few scientifically evidence-based interventions, there is “little consensus about which mental health interventions are most beneficial to whom and at what times during and following a disaster” (McCabe et al., 2004, p. 200). Moreover, there is even controversy regarding the lexicon used for disaster interventions.

Overall, while the importance of evidence-based treatments has become increasingly prevalent in the general psychology literature, it has not acquired similar prominence in the literature on psychological responses to terrorism. This issue, specifically, and the actual implementation of evidence-based treatments is significant—and ought to be addressed at length in another paper.

Training

In the aftermath of September11, the United States mental health professional community began to develop a model for recovery and preparedness, launching a public

information campaign regarding the psychological consequences of terrorism. However, as this campaign began to grow, it became clear that most clinicians in the community had little training in treatment procedures for the psychological sequelae of terrorism (Amsel, Neria, Marshall, & Suh, 2005). Yet other experts in the field (Danieli et al., 2005), highlight the existing need for proper training, not only for credentialing, but also for ensuring quality-control.

Because the Israeli population has been subjected to terrorist attacks long before the US, they have also confronted the extensive experience of terrorism-related psychological trauma. The Mental Health Services of the Ministry of Health in Israel designed and implemented a comprehensive emergency response system that operates in general hospitals and community settings to meet the psychological needs resulting from terrorism at both the individual and the population levels. Training programs for various service providers working with the victims, as well as general premises, basic elements, administrative structure and functioning of this system are delineated by Ben Gershon, Grinshpoon, and Ponizovsky (2005). The basis for this disaster preparedness program is that first responders acknowledge that terrorism casualties are caused by stress; that anxiety, fear, and demoralization may impair both individual and community-wide mental well-being; and that early intervention is beneficial.

In the US, some of the literature has addressed the need for proper training models. For example, Amsel et al. (2005) described the development, delivery, and initial assessment of one attempt to improve training effectiveness beyond what traditional Continuing Professional Education has been able to do. McCabe et al. (2004) highlighted the importance of psychiatry's role, specifically, in preparing the community for the psychological impact of

terrorism—against the historical backdrop of the field being ‘carved out’ from the organization, delivery, and financing of health services in our society. Moreover, the authors offered a “practical framework” for designing an organization's mental health disaster plan, including recommendations for strategic infrastructure and tactical response capabilities.

Garakani, Hirschowitz, and Katz (2004) also discussed disaster psychiatry, as a professional application of mental health knowledge and expertise to the unique setting of terrorism. The authors distinguished disaster psychiatry as (a) encompassing a confrontation with acute trauma and grief to an extent rarely seen in traditional practice, (b) relying on relatively scarce scientific information that underlies immediate post-trauma interventions, (c) depending on an outreach model of practice which requires proactive efforts of the mental health professional in the community, and (d) requiring sound and effective practice of not just general and trauma psychiatry but also of the disaster response system.

Training is also of import on the individual level. As articulated by McCabe et al. (2004), “notwithstanding the unique clinical issues involved in disaster work, perhaps the greatest challenge is the demand to diverge from—some would say, transcend—one’s traditional professional role” (p. 202). Much like when intervening professionally within other non-traditional settings (e.g., bedside with end-of-life patients), the professional ‘boundaries’ in a disaster context are much more fluid, and the professional must work on his/her own fears, terrors, and trauma—while treating the same.

It is important to acknowledge that clinicians are also susceptible to the psychological consequences via secondary traumatic stress, also known as counter transference, vicarious traumatization, burnout, and compassion fatigue. Moreover, there are unique features of clinical practice with victims of terrorism, including intra-clinician conflicts between

professional/community interests and personal/family obligations during acute disaster events. As such, another important aspect of training is professional monitoring and supervision.

CONCLUSION

DIRECTIONS FOR FUTURE RESEARCH

What we know—and what we have learned—about the psychological consequences of terrorism on victims, first responders, and the general civilian population has been discussed. That which we don't know, and have yet to learn, has been explicitly stated in the literature, by expert researchers and scholars in the field.

First, and foremost, there is a need for more research. Although the scope and depth of the research "has increased greatly over the past few years, research and theory about the focused and broader impacts of terrorism are still in the very early stages" (Baum & Dougall, 2002, p. 618). Issues related to the psychosocial management of responses to terrorism have become the latest important development that will contribute to the continuous transformation and growth of behavioral medicine.

In order to conduct this research, we must plan accordingly—and in advance. McCabe et al. (2004) underscore this point: "while America wages the 'war' on terrorism and endeavors to protect the physical safety of its citizens, it is imperative to plan for the population's mental health needs in future terrorist/disaster scenarios" (p. 197). Planning accordingly includes fiscal and monetary changes. Speckhard et al. (2005) add that "if we wish to understand terrorism, better, given the unpredictability of terrorist acts, we need to have funding mechanisms available to quickly put in place and fund studies shortly after the fact" (p. 122).

Planning accordingly also entails a transformation in how we conceptualize the psychological consequences of terrorism, both on the clinical level and the public health policy level. The authors of the white paper by the Interdisciplinary Task Force on Terrorism

of the American College of Neuropsychopharmacology, Yehuda and Hyman (2005) "implicitly suggest that research on the behavioral and psychobiological responses to terrorism requires financial support and enlistment of capable scientists prior to the next attack, but more importantly, it necessitates that scientists and the policy makers reach agreements prior to the next attack, that would permit researchers access to people affected by terrorism as soon as after events as it is safe to do so. Indeed, much if why we have such limited information at the present time results from failure to properly conduct research in the aftermath of prior terrorist events" (p. 1773). Yet, as recently as 2003, the Institute of Medicine reported that the mental health need of planning for the psychological consequences of terrorism had been overlooked. Then, in 2004, Stein et al. (2004) argued that "although substantial efforts are now being made to prepare the public health system to respond to future terrorist attacks, improving the country's ability to respond to the *psychological* effects of terrorism are not yet a large part of these efforts" (p. 114).

Specifically, the experts call for many types of research: longitudinal; more empirically sound; and pertaining to particular populations, diagnoses, interventions, and outcome, to name only a few. Aber et al., (2004) state that "few, if any, of the studies of the effects of September 11th have done so in a developmental or longitudinal framework. Such research designs are needed to help move the field" (p. 113). Silver et al. (2004) also highlight the importance of documenting psychological responses over time. Schlenger (2004) suggests that future studies should use well-validated measures and employ longitudinal design. More specifically, he recommends, more systematic studies to examine causal effect. Such studies could clarify the full range of psychological responses and identify the most deleterious aspects of terrorism, thereby refining and/or creating new

diagnostic constructs, and identifying effective interventions. Finally, Danieli et al. (2005) emphasize the need for longitudinal studies with children: “work on the impact of terrorism on children and adolescents is only now emerging. To date, no single pattern of post-attack outcomes has been identified and no studies so far have used a longitudinal design to assess the long-term impact on children” (p. 777).

The field of coping with terrorism, and resilience pre- and post- terrorist acts, is also a commonly suggested area for future research. Cohn et al. (2004) state that “the field would benefit from research that (a) tracks responses to upheavals as they unfold, providing a continuous time line of coping; (b) goes beyond self report; and (c) compares subjects’ thoughts, feelings, and behavior with their habitual states prior to upheaval” (p. 687). McCaslin et al. (2005) suggest studying the “positive changes or benefits derived from disaster or rescue work” (p. 252). Friedman et al. (2003) proposed investigations of a wide spectrum of individual, group, and community interventions. More specifically, research should explore and/or consider: efficacy, effectiveness, timing, treatment setting, target population, cultural and developmental factors, group debriefings, self-help initiatives, pretraumatic preparation and posttraumatic intervention, all of which may be used to address adaptive functioning, effective coping, and health-seeking behavior.

Sound methodology has also received a lot of attention in the context of future directions for research. Wilson and Rosenthal (2004) explains that “a number of reviews of empirical literature on disaster and distress have been published in the past 15 years” (see citation for reviews). Yet “a recurring refrain within these reviews is the lack of consistency among the findings and interpretations of many studies. This lack of consistency has typically been attributed to one or both of two quite different aspects of the literature, one,

the lack of an appropriate conceptual model for the phenomenon of the occurrence of psychological distress following a disaster, and two, the general methodological deficiencies of the studies" (p. 588). Thus, recommendations in the literature include: use of standardized measures with good reliability and validity; use of appropriate control groups; utility of prospective rather than retrospective studies; and exploration of possible confounding factors, including pre- and post- disaster assessment of psychological distress symptoms.

Friedman et al. (2003) ask "what psychological reactions constitute an adaptive human response to traumatic stress; how do we distinguish adaptive from maladaptive and biological responses or when to do so; what psychological and biological mechanisms are involved in normal recovery from traumatic stress; and what may be unique about children in this regard?" (p. 767). They conclude that: "we can close the gap in knowledge by conducting longitudinal studies with high risk populations in which psychological and biological variables are monitored which appear to predict vulnerability and resilience; promoting laboratory research assessing the relationship between clinical symptoms and specific psychological and biological mechanisms; promoting intervention research in which protocols and potential psychological and biological change mechanisms are monitored along with clinical outcomes; and extending such research to traumatized children at different developmental stages" (p. 767).

We can also address the need to develop conceptual models that distinguish between normal recovery and pathological reactions, and resilience from vulnerability; study the relationship of exposure to traumatic stress responses; explore predictors of PTSD or other pathologic responses; identify who needs emergency mental health services in the wake of terrorist acts; develop interventions which promote resilience and prevent trauma-related

disorders; examine the practice of debriefing in the immediate aftermath of trauma; and develop age-appropriate interventions for children.

Terrorism is, fundamentally, psychological warfare. The present climate of uncertainty and the dearth of scientific knowledge demand our immediate attention. Knowledge will translate into evidence-based, effective interventions which will foster resilience and further enhance coping.

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APPENDIX A

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APPENDIX B

LIST OF EXPERTS ON PSYCHOLOGICAL ASPECTS OF TERRORISM

Although far from exhaustive, the following list sheds some color on those who might be considered experts in the field, based on their number of publications and/or first authorship:

Aber, J. L.
Abu Saba, M. B.
Ahern, J.
Amsel, L. V.
Balas, A.
Baldomero, E. B.
Barnes, V. A.
Baum, A.
Ben Gershon, B.
Blumberg, H. H.
Bonnano, G. A.
Cano Vindel, A
Chen, H.
Danieli, Y
Eidelson, R. J.
Foa, E. B.
Fredrickson, B. L.
Galea, S
Garakani, A.
Gershoff, E. T.
Gil Rivas, V.
Gonzalez, H.
Hoge, C. W.
Hollander, N. C.
Iruarrizaga, I.
Jaycox, L. H.
Khaled, N.
Levant, R.
Malin, A. M.
Mccabe, O.
McNally, R. J.
Miguel Tobal, J. J.
Milliken, C. S.
Munoz, M.
Nixon, S. J.
Pfefferbaum, B. J.
Pfefferbaum, R. L.
Pulcino, T.

Resnick, H.
Schlenger, W. E.
Schuster, M. A.
Shalev, A. Y.
Silver, R. C.
Somer, E.
Speckhard, A.
Stein, B. D.
Stout, C. E.
Tucker, P.
Yehuda,R

APPENDIX C

LIST OF RESEARCH INSTITUTES

Table 1 - Institutes for Psychological Aspects of Terrorism

Table 2 - Institutes for Terrorism, In General

Table 1

Organization	Institute	Location	Website
American Academy of Child and Adolescent Psychiatry (AACAP)		US	www.aacap.org
American Psychological Association		US	http://www.apa.org/topics/topictrauma.html
American Psychiatric Association		US	www.psych.org
Anxiety Disorders Association of America (ADAA)		US	
APA Disaster Response Network	American Psychological Association	US	http://www.apa.org/practice/drn.html
APA Resilience Initiative		US	www.APAHelpCenter.org
Department of Psychiatry & Behavioral Sciences	Miller School of Medicine, University of Miami	US	
Disaster Mental Health Institute	University of South Dakota	US	
Emergency Preparedness and Trauma Treatment	Mental Health Services, Ministry of Health	Israel	
Emergency Services and Disaster Branch, Substance Abuse and Mental Health Services (SAMHSA)		US	
Federal Emergency Management Agency (FEMA)		US	http://www.fema.gov/
Institute of Medicine (IOM)		US	
Interdisciplinary Task Force on Terrorism	American College of Neuropsychopharmacology (ACNP)	US	www.acnp.org
International Disaster Psychology Program	University of Denver	US	
International Journal of Emergency Mental Health			
International Society for Traumatic Stress Studies		International	http://www.istss.org & Journal of Traumatic Stress
International Trauma Studies Program	New York University	US	http://itspNYC.org/

Israel Center for the Treatment of Psychotrauma	Jerusalem, Herzog Hospital	Israel	www.traumaweb.org
Maytal--Israel Institute for Treatment and Study of Stress	University of Haifa	Israel	
Mood and Anxiety Disorders Program	National Institute of Mental Health	US	
National Center for PTSD	Department of Veteran Affairs	US	http://www.ncptsd.org
Parents Circle-Families Forum		Israel	www.theparentscircle.org
Project Liberty		NY	http://www.projectliberty.state.ny.us/
R. D. Wolfe Centre for the Study of Psychological Stress	University of Haifa	Israel	
Traumatology Institute	Florida State University	US	
Unit on Trauma Studies and Services (TSS)	New York Psychiatric Institute/Columbia University	US	

Table 2

Organization	Institute	Location	Website
American Red Cross		US	www.redcross.org
The Brookings Institution		US	/www.brookings.edu
Cato Institute		US	http://www.cato.org/current/terrorism/index.html
Center on Terrorism	John Jay College, City University of New York	US	http://www.jjay.cuny.edu/terrorism/
Centre for Defence and Security Studies	University of Manitoba	Canada	http://www.umanitoba.ca/centres/defence/index.html
Centre for the Study of Terrorism and Political Violence	University of St. Andrews	UK	http://www.st-andrews.ac.uk/academic/intrel/research/cstpv/
Conflict 21-Center for Terrorism Studies (C21)		US	http://c21.maxwell.af.mil/cts-home.htm
ConSec	Miller Center for Contemporary Judaic Studies, University of Miami & Ryder Trauma Center, Jackson Memorial Hospital	US	
Council of Foreign Relations		US	www.cfr.org
Counter-Terrorism Committee	United Nations Security Council and General Assembly		
Department of Homeland Security		US	
Institute for Counter-Terrorism (ICT)	The Interdisciplinary Center (IDC)	Israel	www.ict.org.il
Jaffee Center for Strategic Studies	Tel Aviv University	Israel	http://www.tau.ac.il/jcss/
Jebsen Center for Counter Terrorism Studies	Tufts University	US	http://fletcher.tufts.edu/jebsencenter/index.shtml

Mackenzie Institute		Canada	http://www.mackenzieinstitute.com/
Memorial Institute for the Prevention of Terrorism		US	http://www.mipt.org/
Miller Center for Contemporary Judaic Studies	University of Miami	US	http://www.miami.edu/miller-center
National Consortium for the Study of Terrorism and Responses to Terrorism (START)	DHS & Multiple Academic Institutions, based at University of Maryland	US	http://www.start.umd.edu/
National Memorial Institute for Prevention of Terrorism		US	http://www.mipt.org/
National Security Council, Counter-Terrorism Division		Israel	IsraelNN.com
Office of Emergency Preparedness (OEP)		US	
Office for Victims of Crime	US Department of Justice	US	http://www.ojp.usdoj.gov/ovc/publications/infores/cat_hndbk/welcome.html
Pew Research Center for the People and the Press		US	http://www.people-press.org
Rand Corporation		International	http://www.rand.org/research_areas/terrorism/
Terrorism Research Center (TRC)		US	http://www.terrorism.com
Terrorism Studies Group		US	http://www.terrorism-studies.com/
US Public Health Service (PHS)		US	