Published Online November 16, 2008

Psychological interventions following terrorist attacks

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Background: Psychological reactions to terror attacks have been documented as ranging from no symptoms to transient behavioural symptoms to more serious posttraumatic stress.

Sources of data: A review of representative studies is presented, with a critical analysis of the salient points of the various psychological intervention strategies for terrorist attacks.

Areas of agreement: Common aspects of both most intervention approaches include multifaceted models that foster social support and include a preparatory phase, a phase of 'psychological first aid' and a follow-up phase of referral for more severe cases.

Areas of controversy: The notion of intervention for all who may show some symptoms is not universally accepted. Where treatment or intervention is used, the debriefing aspect of CISM (Critical Incident Stress Management) remains highly disputed, with the focus on intrusively revisiting the trauma appearing to have questionable value at best.

Growing points: Some data questions whether formal treatment or intervention is necessary or even desirable. For many who choose not to seek out any help following a trauma, clinical data shows no negative results. Moreover, the preponderance of data shows that conventional 'debriefing' is not recommended. If the debriefing mechanism is refined so that intrusive emotional rehashing of the traumatic event is eliminated, the resultant interventions resemble resilience based approaches.

Areas timely for developing research: Further defining when intervention is called for and refining the mechanisms of intervention in multi-stage intervention.

Keywords: terrorism/psychological/intervention/debriefing/resilience/social support

Accepted: October 20, 2008

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British Medical Bulletin 2008; **88**: 7–22
DOI:10.1093/bmb/ldn041

Introduction and background

'Terrorism' is not a new term, nor is it a novel phenomenon. As noted by Golder and Williams,[1] its coinage seems to be first associated with the 'Reign of Terror' that followed the French revolution in 1789. Reflecting the political and social colouring associated with the use of the terminology, finding an exact and agreed upon definition is not a simple task. One study in 1988[2] found over 109 different definitions of the expression. The United Nations, European Union and various agencies within the United States all have used differing, although similar wording in referring to terrorism. In the UK, the term is legally defined in the Terrorism Act of 2000 (amended in 2006) to include acts '... designed to influence the government or to intimidate the public or a section of the public and the use or threat is made for the purpose of advancing a political, religious or ideological cause'. The Terrorism Act states that these actions involve serious violence against a person, serious damage to property, endangers a person's life, creates a serious risk to the health or safety of the public, or is designed to seriously interfere or disrupt an electronic system.

Notwithstanding the various definitions and aspects of terror, the psychological sequelae of terror attacks are often no different from symptoms associated with other traumatic events. There may be no symptoms at all and symptoms, when present, can range from mild to severe. Intervention for victims of terror often focuses on conventional treatment associated with stress disorders in general, such as acute or posttraumatic stress disorder. But, as noted by Sederer,[3] terrorism is also 'an effort to destroy the social, emotional and economic fabric of our communities'. These unique circumstances may explain why today's terror victims are often viewed differently from victims of equally or even more horrific violence, such as the 'blitz' of London in WWII or civilian deaths, in general, in conventional wars of the first half of the 20th century. Unlike more conventional trauma, victims of terror are exposed to a distinct set of circumstances that qualitatively separate them from victims of other types of crisis events.

First, terror is not only unpredictable but also man-made and intentional, creating a political, social and ideological overlay not always associated with more conventional forms of trauma. Myers,[4] noting the primary goal of terror as an intention to '... terrify, to fill or to overpower with intense fear, to intimidate ...' states that psychological reactions to terror are more intense and prolonged than reactions to other disasters. Flynn[5] noted other details distinguishing terror attacks such as the lack of any warning whatsoever, the lack of familiarity with the particular details of the event, the particular scope and nature

of the destruction and the uncertainty and disrupted social systems that affect an entire community. While some of these characteristics may also typify aspects of conventional war, terrorism is distinguished by its focus on more ideological rather than purely geopolitical motivations. Whether it is the radical ideology of the Red Brigades or Bader-Meinhof or the more religious ideology of current Islamist jihadists, conventional wars, as noted by some[6] have a distinct end while terrorism, with its focus on altering an ideology rather than simply attaining a geopolitical goal, is never-ending.

Second, while conventional disasters affect both victims and emergency (rescue) personnel, terror, unlike conventional trauma, also influences an audience beyond the immediate victims. In a study following the 11 September 2001 (9/11) attacks in the United States, Schuster and colleagues[7] found that stress reactions to the attacks were felt across the country, with 44% of adults and 35% of children showing what they called 'substantial' symptoms (upsetting reminders, disturbing memories, difficulty concentrating, trouble sleeping, feeling irritable or angry). As such, terror can also be said to cause a 'crisis by observation', affecting people not directly involved. This would be consistent with the findings of Shalev and colleagues,[8] who, in studying two communities (one directly involved and one distant from terror attacks) found that symptoms and posttraumatic stress disorder (PTSD) levels were similar in both groups.

Third, and perhaps most important, is how terror creates an ongoing and constant personal threat in particular societies. Unlike other distinct and discrete crisis events, the threat of terror is continuous and pervasive, creating a need for constant vigilance that is not common in other types of crises and disasters. Unlike other types of crises, one does not have to have personally experienced a terror attack in order to be affected by one. Consistent with the results of the Shalev et al.[8] study, Mansdorf and Weinberg[9] studied two groups of adults in Israel: one that lived in an area that experienced many terror attacks, and another that was exposed to these attacks via observation, but did not personally live near the areas that had experienced attacks. They found both groups were similar in symptoms experienced, although the group that had experienced actual terror attacks in their area also showed markedly higher amounts of perceived stress in their children's behaviour. Since exposure to media coverage of terrorism increases personal vulnerability and creates distinct behavioural symptoms, it has been suggested that pre-attack intervention or preparation might be helpful in dealing with these symptoms.[10]

There is no doubt that terror attacks can have significant psychological consequences. In the United States, the Oklahoma City bombing represented a major loss of life and property, with many causalities.

Both direct victims (survivors)[11] and indirect observers (residents of Oklahoma)[12] of the attack reported significant levels of PTSD. Similar data were reported following the 9/11 attacks, with symptoms of PTSD being higher for those closest to the actual site of attack.[13] In the UK, 75% of those seeking help following the Lockerbie disaster (mostly individuals who knew a victim) reported symptoms of PTSD.[14]

Despite this incontrovertible data, most individuals who have experienced a terror attack may display behavioural reactions but do not necessarily develop symptoms that require professional clinical intervention. As noted by Rubin *et al.*[15] and consistent with other studies,[16] symptoms after a terror attack (e.g. the July 2005 London attacks) are significantly reduced with the passage of time. Furthermore, symptoms that remain are not necessarily indicative of psychopathology or the need for clinical intervention. Bleich and colleagues[17] posited that habituation might be responsible for the fact that serious psychiatric distress is not a necessary consequence of terror attacks. Although there are data indicating that the incidence of behavioural symptoms following terror attacks calls for 'psychological first aid' rather than formal clinical intervention, there are studies that raise questions about conducting any intervention at all. Seery *et al.*[18] has shown that for many individuals, the less emotion they express at the time of trauma, the better off they are. They refer to 'myths of coping' that claim that all affected individuals need help and challenge the notion that formal intervention is a required or even necessary action following trauma. How, when and if to offer intervention is the source of considerable research and debate.

Method

Two broad categories of intervention for victims of terror attacks have commonly been reported in the literature. Critical Incident Stress Management, or CISM, includes 'debriefing' and is the more established, albeit disputed intervention, one that was at one time the standard for treating all kinds of trauma. The second general category involves interventions that focus on personal behaviour and the fostering of coping by tapping into the resilience of affected individuals. Although the term 'resilience' may appear imprecise and elusive to some, the American Psychological Association defined it as '... the process of adapting well in the face of adversity, trauma, tragedy'.[19] Resilience allows people to effectively cope with the stresses of trauma. Significant controversy exists with respect to some of the earlier reported approaches dealing with trauma, especially approaches associated with intrusive debriefing. Less attention has been given to the

defining characteristics of terror-related trauma and how individuals seem to cope and adjust without any intervention at all. For some,[19] 'treating' a terror victim is not only unnecessary, but also may be clinically contraindicated.

Results

Debriefing and CISM

Although CISM has a long history, its efficacy has been questioned. CISM is largely associated with the work of Everly and Mitchell,[20] who claim that its application is often misused and mistaken. They describe a multi-stage approach to CISM and emphasize that the technique is not meant to be psychotherapy, but rather a form of psychological first aid within a multi-component approach where none of the core components are meant to serve as standalone interventions. The seven core components of CISM are: pre-crisis preparation, where expectations are set; demobilization and group briefing, to allow psychological decompression and stress management; defusing, where symptom driven direct intervention takes place; critical incident stress debriefing (CISD), a symptom driven intervention that can take place over a period of several days following the crisis; individual intervention when needed; family and group intervention, when called for and follow up and referral for higher levels of care where indicated.

The most controversial aspect of CISM involves the 'debriefing' phase, where intervention takes place within 24 h of the event. Kaplan *et al.*[21] describe the principal aspects of debriefing as follows: ventilation in a context of group support, normalization of responses and education about postevent psychological reactions. The controversy about this process lies in the mechanism that Kaplan and colleagues describe as behind debriefing; namely, a review of the traumatic experience and encouraging emotional expression to cognitively process the experience. Research on debriefing has yielded what Kaplan *et al.*[21] describe as 'equivocal' results. Deahl[22] conducted an extensive review of the subject, finding 'largely negative' results of randomized clinical trials conducted. But perhaps the defining study that led the British National Health Service to consider debriefing contraindicated[23] for victims of trauma is a review conducted by a UK government supported effort conducted at Oxford known as the Cochrane group study.[24] Their conclusion regarding the common single-session approach to debriefing is direct and blunt: 'Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and

general psychological morbidity. There is some suggestion that it may increase the risk of PTSD and depression'. Others share these rather sober conclusions. In the United States, a collaborative effort between the National Institute of Mental Health, in conjunction with the U.S. Department of Health and Human Services, Department of Defense, Department of Veterans Affairs, Department of Justice and American Red Cross failed to recommend debriefing in posttraumatic intervention.[25] Addressing emergency medical service professionals, Bledsoe[26] presents the simple and unavoidable conclusion that 'CISM is a bad idea and does not work'.

Responding to the proliferation of literature criticizing CISM and more specifically CISD, Everly and Mitchell vigorously reject the arguments. In a review of their model,[27] they note that many of the studies meant to review 'debriefing' are in fact using the term in a manner that the CISM model did not intend. They claim that only when trained individuals properly apply debriefing within the context of the model, can it be evaluated accurately. They further cite Dygrenov[28] who argues that much of the controversy is simply a political debate that relates to a 'threat to the psychiatric elite', although they do not elaborate on what that 'threat' would be.

Reviewing the evidence related to the use of CISM with first responders in the World Trade Center attacks, Hammond and Brooks[29] agree with Emery and Mitchell's defense of the technique. In rejecting the arguments against debriefing, they state that many of the studies that question its efficacy are 'flawed' and that 'debriefings may have been performed improperly, they may have been unstructured or delayed, or the outcome measures used were unclear'. Consistent with Emery and Mitchell's guidelines, they emphasize that debriefing is valuable when properly used, i.e. within the context of a structured, comprehensive approach such as CISM.

Although debriefing may mean different things to different people, the preponderance of research is highly critical of its role in CISM. It is important to note that studies critical of CISM include methodologically rigid research, while many of the reports supporting CISM are based on weaker methodology. In taking a critical view of debriefing, Kennardy[30] suggests that individual factors such as one's perception, premorbid psychological status and expectation of recovery as well as other stressors may affect the outcome of intervention. CISM does not adequately control for these variables, which may be another factor in why critical research tends to view it negatively.

It appears, thus, that claims regarding the effectiveness of debriefing are related to selective use of certain elements of the approach that are not always well defined in classic CISM work. These specific factors rather than the CISM model itself may be what is driving any perceived

effectiveness. It may be that the nature of individual differences in reactions to terror may in fact play a major role in what intervention to use and how or whether to approach individuals suffering from psychological symptoms following a terror attack. This critical element was investigated by Zeidner,[31] who studied a large sample of Israeli adults who were exposed to terror-related violence during the Gulf War of 1991. He found that individuals spontaneously adopted what he termed problem-focused as well as emotional-focused coping strategies to deal with the effects of the situation, with more negative coping resulting with the use of emotion-based approaches. Since, it is the perceived negative consequences of the obligatory and intrusive emotional delving into details of a trauma that debriefing is criticized for, problem-focused strategies are in fact the approach that many clinicians seem to be reporting as an alternative to, or perhaps refinement of, debriefing when intervention is called for. Using somewhat different terminology but essentially standard debriefing techniques, Sijbrandij and colleagues[32] presented a comparison of different types of actual single-session debriefing on non-terror trauma victims. They found that non-terror trauma victims receiving different types of single-session debriefing show little differences, and although psychiatric symptoms are reduced, those who received 'emotional debriefing' (characterized by a high baseline of hyperarousal) tended to show worse results than the other types of debriefing. These results on non-terror victims appear to confirm what many have claimed to be true of debriefing in general as well as with terror victims.

The fact that individual factors in fact determine reactions to trauma was recognized by Brewin's[33] group in screening victims of the July 2005 London bombings. Rather than mandate treatment to all, a staged screening that included self-referrals as well as referrals by health professionals eventually identified those individuals who were felt to be candidates for formal treatment intervention.

Resilience: focusing on personal behavioural styles

Following the attacks of 11 September 2001, the American Psychological Association (APA) published a series of 'fact sheets' that highlighted the use of 'resilience' in dealing with the psychological symptoms that accompany terror attacks. As opposed to the focus on symptoms and pathology that debriefing involves, the APA emphasized that most individuals possess the ability to deal with even high levels of stress and challenge. They cite Masten's view[34] that resilience, the ability to meet and deal with challenging life situations, is the general rule of human adaptation, a view that strengthens the notion that

intervention is not something that should be considered necessary or even desirable in every case. Although the term 'resilience' may appear imprecise and elusive to some, the American Psychological Association actually defined it as '... the process of adapting well in the face of adversity, trauma, tragedy'.[35] Resilience allows people to effectively cope with the stresses of trauma. Although a percentage of individuals will actually develop posttraumatic stress symptoms, the ability to effectively challenge and cope with even highly stressful and traumatic events is something that can be effectively fostered by focusing on individual factors that characterize resilience as well as the social systems and specific coping strategies that allow individuals to master stress and flourish in traumatic situations. This strategy-based approach emphasizing coping stands in contrast to pathology-centred approaches that focus on symptoms and symptom mitigation.

Consistent with this approach, while the largest terrorist attack in history, the events of 11 September 2001, resulted in significant levels of posttraumatic stress disorders,[36] it has been pointed out that 'the vast majority of those exposed to terrorism either display remarkable resiliency or quickly recover'.[37]

Foa *et al.*[38] support the APA's notion that serious psychological distress is not an unavoidable consequence of terror attacks. Citing the example of the reaction of the Israeli public during the first Gulf War in 1991, they state, 'the findings ... dispel the myth that large proportions of people behave irrationally in large public disasters. In fact, the findings provide no reason for concern that substantial numbers of people will be adversely affected from prolonged yet contained traumatic events such as the Gulf war. For all its anxiety, the public behaved rationally throughout and at no point was there any behaviour that can be described as mass panic behaviour'.[39] On a practical basis, Foa and colleagues stress the importance of realistically assessing the damage from any attack, focusing on building resilience and using any number of specific interventions (cognitive behaviour therapy, medication, etc.) for high-risk individuals that actually suffer a serious stress reaction.

Another clear alternative to debriefing and CISM is the 'resiliency management model' as presented by Blythe and Slawinski.[40] Consistent with the approach of the APA, they argue that strategies for intervention in the post-crisis phase should emanate from a strength-based paradigm. Their approach emphasizes social support within a multistep model of a post-incident informational (not debriefing) meeting, a group session review that uses social support to provide techniques for coping, individual sessions for those that require it and follow up and use of additional resources when indicated. Although similar in structure to the CISM model, the absence of detailed delving into traumatic

events during the post-incident (debriefing) phase is what sets this approach apart. Rather than focus on ventilation of emotions and symptoms, the focus is on methods of coping and adaptation.

A variety of clinical approaches that conform to the notion of 'resilience' have been reported in the literature. Lahad[41] introduced an integrated paradigm and treatment model for intervention based on coping and resiliency that clearly aims to utilize individual strengths and resources.

Lahad's model is known as the BASIC Ph, an acronym for beliefs, affect, social skills, imagination, cognition and physical reactions. Since individuals have different reactions to stress that fall into one or more of these categories, their ability to successfully cope with the challenges of that stress are best met by developing resources based on those factors. So, for example, if someone reacts with 'Ph' by being fidgety, jittery or with other trembling-like symptoms, a viable Ph coping mechanism might be physical exercise or even engaging in physical household activity. If one's beliefs include strong religious attitudes, 'B' coping would rely on ceremony and rituals during stressful situations for coping with symptoms such as worry and anxiety. In an example where this model was applied, child victims of rocket attacks in Israel were shown, based on an analysis of their BASIC Ph reactions, to prefer to remain with their families and not be evacuated, despite the presence of shelling and danger.[42] Although this appears to counterintuitive, it again points to the personal nature of reactions to stress in general and terror attacks specifically.

One subset and perhaps precursor of the resilience model is Caplan's concept of 'mastery'[43] which describes how social support fosters the ability to problem solve and develop individual coping mechanisms during periods of stress. The U.S. Department of Health and Human Services, in a publication entitled 'Mental Health Response to Mass Violence and Terrorism',[44] reviews principles of psychological first aid for terror victims, focusing on being '... practical, flexible, empowering, and respectful of survivors' needs to pace their exposure to harsh realities resulting from the event'.[45] Reflecting Caplan's principles, the manual discusses the need to initially buttress social support and provide empathic listening for victims of terror. Psychological first aid follows, taking the form of providing accurate information, allowing personal expression of emotion and promoting problem solving. Consistent with all models that base themselves on resilience, the manual cautions against over involvement with victims who may show serious needs. When workers encounter victims whose reactions may show signs of either serious emotional disorder or exacerbation of a previous mental illness, referral should be made to a mental health professional. Absent such serious symptoms, intervention should be

supportive and responders should be available, but it is imperative to convey confidence in the individual's coping abilities, resilience and ability to solve the challenges they face.

A number of interventions combine different techniques. Mansdorf *et al.*[46] combined the use of social support, mastery and the BASIC Ph technique. Terror victims were provided support to role-play the various coping techniques they would use. By providing feedback and direction during these role-plays, a 'controlled coping' was developed within a system where social support enabled these responses to take hold.

Discussion

Reconciling the approaches

The basic and practical clinical question raised after reviewing the major approaches reported in the literature is whether there is a single, agreed upon or preferred method of intervention. Despite the controversy in the literature and despite apparent semantic differences, such common ground does indeed appear to be present. However, beyond looking at treatment models lies the question of possibly redefining the optimal approach to dealing with terror victims. Considering what type of intervention to use may be secondary to considering whether or not intervention is necessary at all. Such an approach may actually seem to threaten the integrity of some of the treatment models presented up to this point, especially where the model encourages mandatory intervention following a traumatic event. This is true regardless of the type of trauma experienced, but considering that terror is often associated with specific characteristics not present in other types of trauma, this may be especially true of terror victims.

As noted earlier, terror victims are unique and can be differentiated from victims of other types of disaster or trauma. One critical aspect of terror relates to the concept of 'meaning' that takes place following a serious attack. Updegraff and colleagues[47] discuss 'meaning' in terms of how individuals seek to reconcile trauma experienced with personal world views. Part of restoring order to one's private world is anchored in a search for a belief system that restores a sense of security. Even when trauma is great, the adopting of a relevant 'meaning' can mitigate the effects of trauma. With regard to the events of 11 September 2001, Updegraff's group found that finding relevant meaning in the act supported adjustment and reduced fears of future terrorism. Another example of the role of 'meaning' is found in the difficulty of adjustment of Israelis who were evacuated during the disengagement from

Gaza in 2005. Despite the fact that they moved from a life of terror and danger to one of relative physical security, they seem to yearn for their former life. One former resident spoke of the common bonds that were fostered among the communities in the former Israeli settlements in Gaza and the purposeful life he had there, despite the daily danger. Speaking of the almost daily exposure to violence and terror, he said, 'It's funny, but you get used to mortars and rockets'.[48]

Clinically, the work of Ehlers and Clark[49] further mold the role of 'meaning' into mechanisms for treatment intervention for those individuals who develop chronic PTSD. In their model, these individuals are posited to have assigned idiosyncratic personal meanings or appraisals to the trauma that need to be modified. By employing a cognitive therapy model that addresses these traumatic memories, the perceived personal threat and dysfunctional compensatory behaviours used by individuals to deal with the threats are changed.[50]

Where intervention does take place, all approaches stress a multifaceted and integrative approach where social support, provision of brief informational sessions and subsequent provision of some sort of behavioural-based intervention are important. The major issue that separates the various approaches is not whether or not to offer psychological support, but rather the limits in providing it. On the latter point, consistent with data that question whether intervention may be required at all, the evidence appears clear that providing intrusive intervention that may intensify the trauma and not allowing for natural coping to be engaged is counterproductive.

Debriefing as part of CISM, has, as noted earlier, been called into question because of the negative effects caused by requiring replay of the traumatic event, something that many find overwhelming and difficult to handle. Despite or perhaps because of research that has criticized mandatory provision of psychological services, the latest iteration of CISM appears to back off any suggestion that intervention is called for in all cases. Perhaps in response to continued criticism of their approach, Everly and Mitchell[51] appear to present a clarification of their model in citing '10 commandments' of responding to terrorist attacks that appears to differ little from the resilience-based approaches presented above. Their model describes three phases of intervention. The pre-attack phase includes psychological preparation for possible terror events. In the next phase, the acute management phase, intervention, which includes the CISM approach (including debriefing) favoured by the authors, takes place. The final phase, psychological reconstruction, is meant to bring closure to those still showing symptoms of distress and includes what is described as a multifaceted mental health intervention. Although critics may contend that, as noted earlier, the debriefing phase is ill-advised because of the potential

Table 1 Matrix of intervention for terror related trauma

Symptom level	Recommended intervention
Minor-none	Allow natural recovery, limit to education and/or social support to foster individual coping, no formal intervention
Moderate	Foster resilience and individual coping by providing psychological tools; avoid mandatory or intrusive emotional debriefing
Severe	Formal psychological and medical intervention

to expose individuals to emotional experiences that are not productive, a reading of the final 'commandment' appears to clarify the matter. Everly and Mitchell, after providing a series of guidelines that are strikingly similar to most resilience-based approaches, make the case as follows: 'Do no harm! Although well-intended, early psychological support may be counterproductive if: (a) it interferes with tactical assessment and rescue efforts, (b) applied in such a way as to interfere with natural recovery mechanisms . . . or (c) it intensifies the manifest level of experienced traumatization'.[52] It must be noted that Everly and Mitchell were quite sensitive to criticism of their model, noting that such criticism is 'misrepresented and misunderstood' and that any suggestion that CISM may be harmful is a 'misconception' of the data and a 'misrepresentation'.[53] Nevertheless, the 'do no harm' proviso they specify in their '10 commandments' was not present in the presentation of their original model.

Boscarino and colleagues[54] conducted a comprehensive review of interventions following the 2001 World Trade Center terror attacks. The interventions reviewed were all 'brief' treatments of not more than a few sessions and included a variety of approaches, including CISM and debriefing. Their findings were that these approaches were quite effective and that improvements in a number of variables could be attributed to the ability of these approaches to enhance and foster social support as well as provide practical and focused guidance as to how to handle specific emotional and behavioural symptoms. Although they did not differentiate the effects of the various approaches that were studied in their review, neither did they report any evidence of any particularly untoward results of any one approach, such as CISM.

Conclusion

It would appear, then, that while no one definitive treatment for terror attacks exists, there is a consensus on a number of common variables related to effective and intervention. Table 1 presents a matrix of

intervention that summarizes the major approaches in dealing with terror-related reactions.

First, there is a broad agreement that the acute effect of terror attacks is mitigated over time and that not all reactions to terror attacks will result in long-term clinical damage. It is also apparent that not all who experience a terror attack will actually require any formal psychological treatment. This is one reason to take a conservative approach and being very careful in prescribing psychological treatment intervention at all. As demonstrated by McNally *et al.*,[55] some interventions actually worsen rather than improve symptoms of PTSD in trauma survivors. Second, where symptoms exist and intervention is deemed necessary, such intervention is best approached from the perspective of a multimodal perspective that includes fostering social support and personal coping skills. While the various approaches differ with regard to details, the broad paradigm appears to favour a pre-attack educational or awareness phase for the community at-large, an early intervention 'first aid' phase that does not overly emphasize the traumatic aspects of the event for those individuals with symptoms that are deemed to require intervention, and a follow-up phase where more serious cases are referred for clinical intervention. There is broad support for the notion that mandatory, intrusive debriefing that characterized the popular understanding of how CISM is applied is in fact both unnecessary and potentially harmful.

With regard to community involvement, the American Red Cross presents one example of an effective social support intervention.[56] In discussing preparing for a disaster, there is great emphasis on practical steps to take such as having supplies and equipment. An entire section is devoted to the importance of maintaining contact with family (the main conduit of social support) during and after a disaster. Although seeking help for injuries sustained is mentioned, nowhere is there any mention of any recommendation for seeking out any sort of psychological help following a disaster. Having a proper framework for intervention following a terror attack does not necessarily mean that formal psychological treatment should be initiated at all. It is critical that over-treatment does not take place. Often, disasters are followed by an explosion of well-meaning but often poorly prepared volunteers seeking to provide psychological assistance. This needs to be put into proper perspective by those who direct and mange operations following terror attacks.

Ultimately, as noted by Karanci,[57] since terrorism has broad population effects, intervention involves preparation that must engage social support and multiple levels within the community; responders, professionals and community organizations. This approach is not clinical, but rather sociological, in that the natural mechanisms of community

support and individual coping are tapped prior to any formal clinical intervention for those that may show serious symptoms at a later stage. In the end, scientific-based interventions and strategies continue to be developed and refined as training, supervision and evaluation of past events continues.

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