Routledge
Taylor & Francis Group

Journal of Aggression, Maltreatment & Trauma

ISSN: 1092-6771 (Print) 1545-083X (Online) Journal homepage: http://www.tandfonline.com/loi/wamt20

Terrorism

Mooli Lahad

To cite this article: Mooli Lahad (2005) Terrorism, Journal of Aggression, Maltreatment & Trauma, 10:3-4, 667-679, DOI: 10.1300/J146v10n03_01

To link to this article: https://doi.org/10.1300/J146v10n03_01

SECTION VII INDIVIDUAL AND COMMUNITY PREPAREDNESS: NEW METHODS OF MENTAL HEALTH SERVICES FOR THE 21ST CENTURY

Terrorism: The Community Perspective

Mooli Lahad

SUMMARY. This article examines the effect of terrorism on communities. Its specific point of view is that of resiliency rather than psychopathology. To this end, both a review of the literature on the impact of terrorism on communities in general and the close to home experience of communities in the north of Israel comprise this study. The conclusions drawn lead to practical recommendations for preparing communities both on the national level and at the

Address correspondence to: Mooli Lahad, PhD, Director of the Community Stress Prevention Center, Kiryat Shmona, POB 797, Kiryat Shmona, 11012, Israel (E-mail: lahadm@netvision.net.il).

[Haworth co-indexing entry note]: "Terrorism: The Community Perspective." Lahad, Mooli. Co-published simultaneously in *Journal of Aggression, Maltreatment & Trauma* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 10, No. 3/4, 2005; and: *The Trauma of Terrorism: Sharing Knowledge and Shared Care, An International Handbook* (ed: Yael Danieli, Danny Brom, and Joe Sills) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2005. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

http://www.haworthpress.com/web/JAMT

Digital Object Identifier: 10.1300/J146v10n03_01

local authority level to deal with the long-term psychological results of terror.

KEYWORDS. Terrorism, resiliency, coping, uncertainty, psychopathology, community, preparedness, Israel

Although terrorism has a strong influence on individuals, its intended effect is to intimidate large groups, communities, and nations. The two major questions discussed in this article are, "Can we really assess the mental well-being of large communities?" and "What do we know about the ability of communities to live with terrorism and to build resiliency in the face of the uncertainty with which terrorism confronts us?"

In an Institute of Medicine (IOM) report, Stith-Butler (2003) states:

> Much of what is used to determine how individuals and communities may react to terrorism is derived from broader trauma literature, including that which examines disasters. Although there may be some similarities between other types of disasters and terrorism, the malicious intent and unpredictable nature of terrorism may carry a particularly devastating impact for those directly or indirectly affected. (p. 4)

In most cases of natural or industrial disasters, communities can predict the location, give some warning, and assess directives and routes to safety. More than anything, many of these catastrophes can be categorized under "acts of God" or unintended harm or neglect. None of the aforementioned is possible with acts of terrorism.

In a National Center for PTSD Fact Sheet, Norris, Byrne, and Kaniasty (2003a) scanned 177 articles that described results for 130 distinct samples comprising over 50,000 individuals who experienced 80 different disasters. These studies were coded for the presence of six sets of outcomes and rated for overall severity of impairment. Posttraumatic Stress Disorder (PTSD) was the most prevalent outcome (67%), followed by depression (37%) and anxiety (37%). Non-specific distress, social and interpersonal disruptions, and psychosocial resource losses each were found in 10% or less.

MAGNITUDE OF EFFECTS

To provide a rough estimate of the overall impact of the events studied, the results of each sample were classified on a four-point scale of severity (Norris, Byrne, & Kaniasty, 2003b):

1. Nine percent showed minimal impairment, meaning that the majority of the samples experienced only transient stress reactions.
2. Fifty-two percent showed moderate impairment, wherein prolonged but sub-clinical distress was the predominant result.
3. Twenty-three percent showed severe impairment, meaning that 25 to 49% of the samples suffered from criterion-level psychopathology.
4. Sixteen percent showed very severe impairment, meaning that 50% or more of the samples suffered from criterion-level psychopathology.

ASSESSING THE MENTAL WELL-BEING OF COMMUNITIES

The disruption and sometimes destruction of continuities manifest themselves in some communities by lowering the inhabitants' belief that anything will change, such as their self-perception as victims and their sense of "learned helplessness" (Kalish, 1999). The impact may be long lasting. Ayalon (1983a) described coping abilities of different communities when faced with terrorist invasions of their settlements. Her overall findings were that settlements that had pre-attack community organizational preparedness and support systems in place fared better than those with a loose community structure, where members felt less cohesion and did not have these systems. This study highlighted the benefits of a close-knit societal structure, such as the Kibbutz (an Israeli communal settlement based on socialist ideology of shared property and life style), that on calm days members may perceive as intrusive and domineering. The structure of these Kibbutzim enabled them to maintain four continuities:

1. Logical rules: There was a contingency plan in place.
2. Role: Each member knew his or her role, what was expected of him or her in that role, and who would replace him/her.
3. Social: The concerted way the Kibbutz was running enhanced the feeling of togetherness.
4. Historical: Continuity was reinforced by previous experiences of surviving hardship together and the ideology of shared fate and responsibility.

However, Niv (1994) showed that with the structural change of the Kibbutz movement towards more private life and privatization of services and property, the cohesion and emergency preparedness system collapsed. One example of this change became apparent after a massive attack in 1993 (10 days of shelling by terrorist organizations from southern Lebanon) on the same kibbutzim that functioned well in Ayalon's (1983b) study. They were unprepared, and the rate of unorganized, spontaneous evacuation of the Kibbutz was

significant both socially and economically. Fewer people were available to take care of the children in the shelters, and some of the kibbutzim, for the first time in their history, were unable to work their dairy farms. Based on Niv's findings the regional council developed a new plan. The focus was on a coordinating body based on the existing manpower present in the Kibbutz at any given time, volunteering members to fill positions previously held by full-time workers, a psychosocial team, and an emergency plan for the education system based on volunteering parents (Lahad, 2000).

THE ABILITY OF COMMUNITIES TO LIVE WITH TERRORISM: LIFE ON THE BORDER 1974-2000

The northern town of Kiryat Shmona has seen multiple terrorist attacks for a period of almost 30 years, beginning with the 1970s Katyusha rocket attacks. However, it was not until the terrorists' infiltration in 1974 that the level of anxiety, helplessness, and hopelessness affected large parts of the population. Twenty-two inhabitants were killed in that attack, including mothers and children, and this seriously affected the routine of daily living in the town and in its inhabitants' basic sense of security.

Zuckerman-Bareli (1978) compared the abilities of villages to those of Kibbutzim in the inhabitants' perception of their ability to cope with the prolonged stress. She found the following factors to be responsible for villagers feeling much less secure than the kibbutzim: (a) low level of education, (b) dissatisfaction with the local leadership and with living conditions, (c) absence of organization for emergencies, (d) low income, and (e) personal anxiety not necessarily connected with a "real" attack. The kibbutzim fared better in local organization for meeting crises by having well defined roles for members, social support, and group cohesion.

Ahronstam and Wolf (1975) and Maoz, Weisenbeck, Rosenbaum, and Rabor (1975) conducted several studies on the impact of living under constant threat of terrorist attacks and described the impact on the young and the adult population. Their findings showed that fear, anxiety, and insecurity were prevalent across age groups. Adults showed somatic problems, including cardiac, insomnia, and respiratory difficulties, and children stuttered and suffered from enuresis. Military and civil defense operational planning were in place as the law required; however, the behavioral aspects, or the psychosocial elements of preparedness and response to crisis, were not developed and activities in this area were random, ad hoc, and uncoordinated.

Despite the known, detrimental consequences of the lack of preparation on the behavioral dimension, and despite the various recommendations of official reports, it took the local authorities in Kiryat Shmona 4 years until the first

structured attempt to build a psychosocial response capability in the town began (Lahad, 1981). Based on Ayalon's study on the impact of face-to-face confrontation with terrorism and the conclusion of military surveys, the first psychosocial preparedness plan and training were conducted in two towns in the north of Israel, Nahariya on the eastern coast (Ayalon, 1993) and Kiryat Shmona (Ayalon & Lahad, 2000). The method adopted was a multi-agency simulation to reveal the behavioral, emotional, and social implications of exposure to terrorist attacks and the need for multi-agency preparedness and response capability.

THE COMMUNITY MODEL

The need for a coordinated psychosocial medical education and community-based intervention team was one of the foremost recommendations emanating from the 1980 10-day stay in shelters in the town of Kiryat Shmona. The comprehensive psychosocial plan drawn up at that time later developed into Tel Aviv's metropolitan preparedness program.

The community model was guided by the following assumptions:

1. There will never be enough professional workforces to respond to all needs.
2. There are areas where different professions overlap.
3. There are gaps in services that need to be detected.
4. There is a need to nominate a lead agency.
5. There is a need to coordinate interventions.
6. There is a need to agree on basic intervention protocols.
7. The aim should be as much as possible to help locals help themselves.
8. People are naturally resilient and most need only appropriate preparation and guidance to bring out the best in them under emergencies.

Based on these assumptions, a coordinating committee that consisted of the heads of social, education, mental health, school psychology, primary care, and community centers chaired by the social services was formed. Psychosocial intervention teams of mental health and social work professionals were formed and dispatched to assess the situation and intervene on the individual, family, or group level. A community outreach team comprised of welfare and community workers scanned the towns' shelters on a daily basis to identify needs, support those in need, and enhance self-care and leadership among the citizens. A third team of primary care nurses with a general practitioner and a psychologist was formed to be on call whenever any of the above two teams reported medical or emotional needs or when there were injuries as a result of the terrorist attack.

The education system and community center's staff developed informal education teams to support and activate children of all ages in the shelters or in the near vicinity. Last but not least, media and information dissemination services were developed. These were comprised of an information center, hotline telephone, local interactive TV broadcasting from the town to "meet your leadership," and a local radio station to give instructions and information. To shorten the distance and speed up the response to local needs, the community centers, schools, and kindergartens became neighborhood centers for locals to call in or ask for help. A major volunteer recruitment effort was launched to train in a variety of skills including medical first aid, emotional support, multi-lingual response at information centers, education, and practical skills.

ELEMENTS OF COMMUNITY PSYCHOSOCIAL PREPAREDNESS: RISK FACTORS IN A COMMUNITY

Just as there are risk factors that increase potential long-term negative effects of disasters on individuals, there are risk factors that affect a community's ability to respond to a disaster. Kulka et al. (1989) describe several.

Prolonged Exposure to Event. When there is prolonged exposure to a disaster, it is likely the community will experience a breakdown of significant portions of its infrastructure, making recovery much harder. As Williams, Zinner, and Ellis (1999) explain, "If the tragedy involved massive dislocation or relocation, long-term unemployment, and/or widespread property destruction, the catastrophe may challenge the identity and even the structure of that community" (p. 8).

Repetitive Events. Communities recover when there is a belief that things can return to "normal." This is not the case for communities that experience repetitive terrorist attacks. For them, there is a repeated risk and encounter with loss and damage.

Intentionality of Traumatic Events. Communities are at higher risk for intense grief or traumatic reactions when there is a sense that their trauma was brought specifically to them. This is very much the case with terrorist acts in which the terrorists specifically unleash destruction and fear on the population with the intention of inflicting horror and disrupting the routine of life.

Raphael's (1986) discussion of how a community's nature and culture influence its reactions to a natural disaster is applicable to communities struggling with terrorism. She notes that the most influential variables in determining how a community will respond to a natural disaster are its degrees of poverty, deprivation, underdevelopment, and socioeconomic vulnerability. She also states that a community's willingness or preparedness to cope with a disaster depends

on its sense of vulnerability to the threats, the trust of its citizens in public authorities, its communication system, and the costs of preparedness and response.

One of the few organized attempts to address this issue was launched following the spontaneous evacuation of Kiryat Shmona by its residents in 1980, in reaction to a weeklong rocket attack resulting in two fatalities. The psychosocial and community center's recovery plan included home-based support groups led by community personnel, local officials, and military commanders. The main aim was to express the leadership's genuine interest in the public's opinions and feelings and to restore the citizens' trust in local government and the army's ability to protect them.

Other measures of the community recovery plan were: (a) training local women as civil defense officers and assigning them as "shelter commanders," (b) training parents as informal shelter education staff, (c) teaching them how to engage children through simple arts and crafts activities, and (d) training citizens in basic shelter maintenance skills. These measures ended their total dependence on the municipality for any and every service (Shapiro & Amit, 1982).

THE EMERGENCY BEHAVIOR OFFICER: A NEW PROFESSION

Decision-makers, be they mayors, chiefs of police, fire brigades, army officers, or ministers, typically are in charge of local emergency services, although often they lack training in understanding the needs of the public when responding to disasters. In some cases, because of their training, military or police officers confuse the public with the "enemy." A classic example of this was the Hillsborough football stadium disaster in Sheffield, England in April 1989, where 96 fans were crushed to death due to officials who were attempting to control the crowd and confusing fans trying to escape the crush with hooligans trying to invade the pitch (field). Very often, decision-makers and local councils hold myths about human behavior in emergency situations. In contrast to such myths, Dynes, Quarantelli, and Kreps (1972) described the following facts on the basis of 70 years of research:

1. Disaster victims cope very well. They help their families, neighbors, and co-workers.
2. Panic is so rare that it is not a problem.
3. Looting is rare. Crime rates fall after disasters.
4. People with emergency responsibilities do not leave their posts in a disaster. In more than 500 field studies, the Disaster Research Center at the University of Delaware did not discover a single example of role abandonment.

5. Organizations are at a disadvantage in disasters. Victims can look around them, see what has to be done, and then do it. Communication and transportation damage may make it impossible for organizations to do the same. They are ready and willing to help but may not have adequate access to information or equipment.

Myths become dangerous when organizations act on them. Fearing panic, radio stations hold back warnings. To prevent looting, police devote their resources to security. On the assumption that victims cannot cope, impact areas are evacuated. Imagining the victims to be helpless, outsiders rush to help, causing congestion.

The public may be viewed as helpless, resulting in a decision not to inform citizens about what is happening for fear they will panic. In other cases, the public may be viewed as unimportant, and thus public reactions are not considered as a factor in decision-making. People's natural resilience is not given its true weight. As a result of the establishment of the coordinating body of psychosocial medical and educational services, a new profession was designated–the Emergency Behavior Officer (EBO). The first body to adopt the concept and develop structure, organization, and method of operation was the Israeli Home Front. This role was further adopted by the Ministries of Education, Welfare, and Health.

During 1985-1986, the Community Stress Prevention Center (CSPC) trained the first group of EBOs in skills necessary to understand the human aspects of critical incidents and the many factors influencing public reactions. This training included disaster management, human reaction to disasters, organization and community reactions to disasters, and the difference between an individual-focused approach and an organization and community mental health focus. Some of the skills taught in this initial training were: (a) accumulation of data and information on mass behavior, (b) presentation of a central behavioral picture, (c) predicting public reaction using human sciences, anthropology, mass media, and social psychology, (d) offering suggestions and recommendations to decision-makers at the headquarters level, (e) supporting rescue operation teams, and (f) compiling recommendations based on alternative courses of action.

The overall frame of reference was of resiliency and coping based on the integrative model of resiliency BASIC Ph (Lahad, 1993) as a paradigm both for understanding how a community copes and as the basis for communicating with decision-makers and the public and using the media as a source of support (Lahad, Peled, & Cohen, 1995). To date, there are hundreds of trained EBOs in Israel and in other countries serving as consultants on human behav-

ior and community stress prevention. The information in Table 1 was developed for the training of the EBOs in community stress prevention.

WHEN RESOURCES ARE SCARCE: REMOTE COMMUNITIES CARING FOR THEMSELVES

The capacity to provide the above services does not exist everywhere. Gilad and Cohen (1988) describe the attempts to establish a community self-help system where very little professional help is available, or where it would take time for it to arrive following a terrorist attack. This concept, later developed by many small communities in Israel, is based on three components:

1. Screening and mapping: Looking for professionals within the community.
2. Getting volunteers and training non-professionals: Using community outreach and empowering methods, locating volunteers to cover all aspects of community life: logistics, security, education, social, religion, medical, morale, emotional and information; training them in disaster management and community networking and support.
3. Self-management and information dissemination: Training volunteers (professionals and non-professionals) to operate the community as long as it takes and to be able to coordinate with outer bodies (e.g., government, army, hospitals, regional council) until the emergency is over.

Brender (2001) surveyed the operation of these community emergency teams for the Israeli Ministry of the Interior and found that overall satisfaction of the inhabitants with the teams' activity was very high (almost 94% of the interviewees). When he asked the teams what helped them to cope with the situation, they mentioned cooperation of citizens, volunteering of adults and youth, support from the community leadership and establishment, the team's training prior to the Intifada (the Palestinian uprising), simulations in the community, outside support, the welfare department of the regional council, and learning and rehearsing the procedures and contingency plans.

CONCLUSIONS AND RECOMMENDATIONS

Terrorism can be seen as the disease of the 21st century; its ability to influence masses will probably grow as a result of the availability of new technologies, weapons of mass destruction, and the construct of the "global village"

TABLE 1. The Public's Expectations from the Community Organization

Preparedness (Primary prevention)	*Response* (Secondary prevention)	*Recovery* (Tertiary prevention)
* Contingency plans	* Quick response	* Resume control
* Prevention activities	* Save life & property	* Quick return to normal
* High competence of personnel	* Contain the risk	* Assistance in solving personal problems
* High readiness	* Control the damage	* Preserve victim's rights
* Keeping obligations	* Quick response to the victims	* Taking care of the public at risk
* Public preparedness	* Law enforcement	* Control the situation
* Information for public	* Provide clear instructions	* Long-term mental support (instructions, addresses)
	* Information dissemination	* Provide for victims' needs

that makes the impact of terrorism global. The psychosocial field is still very much behind other aspects of disaster planning and preparedness and will continue to be this way as long as decision-makers fail to understand the need to invest resources in this field comparable to those which are poured into the strategic and logistical ones. There is a clear paradox of investing billions of dollars in equipment and materials, whereas investment in social and emotional resiliency that pays off for years to come receives very little and in some cases next to no funding. The need for such investment is crucial for the sustainability of any nation's reactions to large-scale terrorist attacks and the concomitant mass disasters.

At the decision-making level, there is a need to see a raised public awareness of the impact of such incidents, bearing in mind that PTSD should not be the primary factor advocate but rather the immediate numbers of the public who are psychologically and behaviorally affected by the disaster. In a recent report of the Israeli Ministry of Health (Ben Gershon, 2003), the ratio is 1 physically injured to 13 people emotionally affected. This alerts us to the need to make plans to speed up the recovery and return to functioning of people who would otherwise be an enormous burden on the system, even for 3 to 6 weeks. The other side of this awareness is to instill the knowledge that the public will recover and that almost everyone will be able to function well if instructed beforehand and assisted, guided, and supported during and after the incident.

On a national level, a system focusing on the psychosocial aspects of disasters must be developed (the Emergency Behavior Consultancy System [EBCS]). The task of the EBCS should include (a) advising policy makers,

(b) building a database, (c) developing tools and methods to analyze information in "real time," and (d) coordinating agencies and services dealing with the public during normal times so that the response will be well organized and resources will be better utilized. The EBCS should function at all levels: (a) headquarters (decision-makers), (b) intervention teams, and (c) ground level (in the community). Additional factors would have to be taken into consideration with terrorist attacks, including the public's reaction to the perpetrators (such as the wish for revenge, not always directed at only the perpetrators) and the altered perception of what constitutes a safe activity (such as traveling on a bus and eating in a café).

Another aspect of psychosocial preparedness should be on the local authority level, building upon existing services and adopting the concept of "helping the public to help themselves," that is, enhancing "motivational resiliency." We recommend adapting the Israeli model of coordination teams of all the services and agencies dealing with the public, namely welfare, health, education, community services, non-governmental organizations (NGOs), clergy or other cultural services, information, public shelters, and mental health services. The community response teams model (Brender, 2001; Gilad & Cohen, 1988) is recommended for adoption by small, remote communities that may be subject to attacks and where distance or scarcity of professional help necessitate a locally-led response.

All plans and systems need to be culturally sensitive, utilizing local resources and communicating in a culturally accepted manner. As some research indicates that the source of support and information for many people lies in the neighborhoods, we suggest a neighborhood liaison system based on volunteers and existing services.

Finally, the family as a source of preparedness and support before, during and after the incident is another crucial element in the community's ability to face crisis. In the case of terrorist incidents, this crisis is generally longer term and much wider focused than after a natural disaster or accident. Parents and family need to be engaged in the process. Much has been written on this subject but very little was done in this area, and even fewer studies were carried out to test what are the most important aspects of family preparedness (Rosenfeld, Caye, Ayalon, & Lahad, in press). The community provides its members with a context for coping with their daily life as well as for the meaning they attribute to disasters. It is, therefore, of major importance to study more carefully successful as well as unsuccessful attempts by communities to deal with the aftermath of disasters, and to develop tools to assess the capabilities or resilience of communities prior to catastrophes.

REFERENCES

Ahronstam, S., & Wolf, O. (1975). Kiryat Shmona project. *Journal of Psychology Counseling and Guidance in Education*, *8*, 94-101. (Hebrew).

Ayalon, O. (1983a). Coping with terrorism: The Israeli case. In D. Meichenbaum & M. Jaremko (Eds.), *Stress reduction and prevention* (pp. 293-339). Cambridge, MA: Perseus Publishing.

Ayalon, O. (1983b). Face to face with terrorists. In A. Cohen (Ed.), *Education as encounter* (pp. 81-92). Haifa, Israel: Haifa University Press. (Hebrew).

Ayalon, O. (1993). Post traumatic stress recovery. In J. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 855-866). New York: Plenum Press.

Ayalon, O., & Lahad, M. (1991). *Life on the edge: Coping with stress of war and peace*. Haifa, Israel: Nord Publications. (Hebrew).

Ayalon, O., & Lahad, M. (2000). Coping with uncertainty. In O. Ayalon & M. Lahad (Eds.), *Life on the edge: Coping with stress, war, security hazards, violence*, *2000* (pp. 327-347). Haifa, Israel: Nord Publications. (Hebrew).

Ben Gershon, B. (2003, August). *The Israeli Ministry of Health preparedness plan for mass casualty incident*. Paper presented at the Cherish Conference, Cyprus, Nicosia. (Hebrew).

Brender, M. (2001, February). *Evaluation of the effectiveness of the Community Emergency Teams* (CET). Report presented to the Ministry of Interior, Jerusalem, Israel. (Hebrew).

Dynes, R., Quarantelli, E., & Kreps, G. (1972). *A perspective on disaster planning* (Report Series No.11). Newark, DE: Newark Disaster Research Center, University of Delaware.

Gilad, M., & Cohen, A. (1988). Preparing non-professional volunteers for crisis and Emergency. In M. Lahad & A. Cohen (Eds.), *Community stress prevention* (Vols. 1-2; pp. 154-159). Kiryat Shmona, Israel: Community Stress Prevention Center.

Kalish, N. (1999). *Youth in high school coping in an uncertain reality of life; The relationship between one's outlook on life, political awareness, declared level of religiosity and anxiety level*. Budapest, Hungary: Department of Education, Faculty of Arts at Eötvös Loránd University, Budapest.

Kulka, B. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. A. (1989). *Trauma and the Vietnam War generation: Reports of findings from the national Vietnam veterans adjustment study*. New York: Brunner/Mazel.

Lahad, M. (1981). *Preparation of children and teachers to cope with stress: An integrative approach*. Unpublished masters thesis, Hebrew University, Jerusalem, Israel. (Hebrew).

Lahad, M. (1993). BASIC Ph: The story of coping resources. In M. Lahad & A. Cohen (Eds.), *Community stress prevention* (Vols. 1-2; pp. 117-145). Kiryat Shmona, Israel: Community Stress Prevention Center.

Lahad, M., Peled, D., & Cohen, A. (1995). *Emergency behavior officer training manual*. Ramat Gan, Israel: DEMCO.

Lahad, M. (2000). *Kibbutz emergency contingency plan*. Kiryat Shmona, Israel: CSPC (Hebrew).

Maoz, B., Weisenbeck, H., Rosenbaum, M., & Rabor, M. (1975). *Community psychiatry in the Upper Galilee* (conference report) pp. 150-158. (Hebrew).

Niv, A. (1994). *Communities under fire–The Kibbutzim of the Upper Galilee*. Report to the United Kibbutzim Movement, Ruppin Institute, Working paper. (Hebrew).

Norris, F. H., Byrne, C. M., & Kaniasty, K. (2003a). *Risk factors for adverse outcomes in natural and human-caused disasters: A review of the empirical literature. A national center for PTSD fact sheet*. Retrieved from, *http://www.ncptsd.org/facts/disasters/fs_riskfactors.html*

Norris, F. H., Byrne, C. M., & Kaniasty, K. (2003b). *The range, magnitude, and duration of effects of natural and human-caused disasters: A review of the empirical literature: A national center for PTSD fact sheet*. Retrieved from, *http://www.ncptsd.org/facts/disasters/fs_range.html*

Raphael, B. (1986). *When disaster strikes: A handbook for the caring professions*. London: Hutchinson.

Rosenfeld, L. B., Caye, J., Ayalon, O., & Lahad, M. (in press). *When their world comes apart: Helping families and children manage the effects of disasters*. Washington, DC: NASW Press.

Shapiro, D., & Amit, M. (1982, September). *Survey of tendencies to stay or leave Kiryat Shmona following a terrorist attack*. A survey for the Kiryat Shmona Municipality. Kiryat Shmona, Israel: Kiryat Shmona Municipality publication. (Hebrew).

Stith Butler, A., Panzer, A. M., & Goldfrank, L. R. (Eds.) (2003). *Preparing for the psychological consequences of terrorism: A public health strategy*. Washington DC: National Academies Press.

Williams, M. B., Zinner, E. S., & Ellis, R. R. (1999). The connection between grief and trauma: An overview. In E. S. Zinner & M. B. Williams (Eds.), *When a community weeps: Case studies in group survivorship* (pp. 3-16). Philadelphia: Brunner/Mazel.

Zuckerman-Bareli, C. (1978). The effect of border tension on the adjustment of kibbutzim and moshavim on the northern border of Israel: A path analysis. In C. D. Spielberger & I. G. Sarason (Eds.), *Stress and anxiety* (pp. 81-91). New York: McGrew-Hill International Book Company.