Midway Evaluation

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Terrorized populations or resilient societies?

Health and societal consequences of terrorist attacks in non-conflict societies

Thank you all for taking the time to read this summary of my PhD-project this far and the attached working paper. I am looking forward to hearing your feedback!

When it comes to the overall plan for my project I am in particular interested in discussing the overall composition of the dissertation in terms of the five papers, more specifically whether the suggested papers are suited for addressing the overall research questions and formally whether they are sufficient, given that most of them are co-authored papers. When it comes to the working paper, it is still quite descriptive in some parts, and any suggestions for how to better frame it theoretically would be much appreciated. Otherwise, any other feedback on both the PhD-summary and the paper is greatly appreciated!

The PhD project is part of the interdisciplinary research project 'Prospective Research on Terrorist Events and Collective Trauma' (PROTECT), which attempts to integrate perspectives from medicine and the social sciences when studying individual and group reactions in the aftermath of terrorist attacks. The overarching aim of PROTECT is to strengthen the public health preparedness and response to terrorist attacks and other mass trauma**,** and further to develop a solid research methodology that allows for comparison of post-disaster health service provision across Europe**.** Two countries, Norway and France, are utilized as overarching cases in the project, but the intention is for the findings to be relevant for Europe in general and potentially beyond.

My PhD project will contribute to the objectives of PROTECT, through integrating perspectives from terrorism studies, public health research, and political psychology, to study whether terrorist attacks are indeed associated with deteriorating health in the population, whether health reactions after terror are associated with political responses in the population, and finally, how this is addressed by governmental responses and policy. More specifically, my dissertation intend to address the following three research questions:

1. To what extent will terrorist attacks generate stress reactions in different groups of the population?
2. What shapes and characterizes the governmental responses to health reactions in the population after terrorist attacks?
3. To what extent is exposure to terrorism (and subsequent health reactions) linked to political responses and perceptions of public systems?

Background

Terrorist attacks represent a particular form of political violence, of which a central intention is to create fear and affect populations beyond those directly affected by the violence (Hoffmann, 2006). More research is needed, however, to assess consequences in the population. The severity, and the "quality" of terrorist attacks are often assessed through quantifying fatalities (see e.g. Calle & Sánchez-Cuenca, 2011). While useful for some purposes, such measures may conceal other types of consequences that may be pivotal to account for in order to gain a more comprehensive understanding of the broader social effects of terrorist attacks. Given that a defining feature of terrorism is the intention to create fear, often by shocking a wider audience through the use of spectacular attacks and killings, these effects may to some extent be palpable regardless of the number of people killed. There are reasons to assume that under some conditions, even attacks with relatively few fatalities can create widespread shock and fear. Thus, more knowledge on a wider range of individual consequences at the societal level is needed. Linked to this, there is currently an increasing interest within political psychology and related fields in the so-called "micro-foundations" of political responses, such as psychological and emotional responses to political violence, and how this relates to political responses (Canetti-Nisim, Halperin, Sharvit, & Hobfoll, 2009; Nussio, 2020). Gaining further insight into a broader range of human consequences of terrorism, including how different groups of the population may be affected differently by political violence, is key to understand more about these 'micro-foundations'

A central aim of this project is therefore to discuss how the effects of terrorist attacks can be understood in competing and complementing ways, through looking at the effects such incidents have on the population's health, how this in turn can be associated with political responses, and finally how it is responded to by the institutions responsible for serving this group and their health concerns. Through this, the PhD project will contribute to theoretical discussions

regarding terrorist incidents and their aftermaths, while also obtaining empirical knowledge relevant for strengthening the preparedness and response to terrorist attacks.

An overview of the papers to be included in the dissertation

I currently have five papers planned for the dissertation.

Paper 1: Preparing for the Unexpected: A comparative study of policies addressing post-terror health reactions in Norway and France

Qualitative paper utilizing policy documents as its data.

Co-author: Lise Eilin Stene, I am the first author.

Summary:

Terrorist attacks occurring in generally peaceful and stable democracies are typically followed by a number of political responses designed to meet the needs of those directly affected and of the general population. Because terrorist attacks affect several interrelated parts of society, including health, justice, and security, political measures will often need to be multifaceted and dynamic. Additionally, such emergencies may incite reforms to existing systems. More comparative research is needed in order to gain a better understanding of these responses and how they develop. The main aim of the current study was therefore to investigate how governments in generally peaceful democracies address the civilian population's needs as related to health and wellbeing after a terrorist attack. More specifically, we looked at intentions for action, as expressed through policies and plans, addressing concerns related to health and wellbeing in the population post-terror.

Using document analysis, we analyzed the plans for post-terror health response in Norway and France respectively and comparatively, related to the 2011 attack in Norway, and three attacks that occurred in 2015 and 2016 in France. Walt and Gilson's (1994) model developed for the analysis of health policy, which focuses on the four concepts context, process, content, and actors, was employed for this purpose. Through this analysis, the intention was to shed light on how different countries respond to intentional, manmade disaster, and the degree to which these processes reflect the health systems in which they are implemented and the nature of the terrorist incidents. Differences between terrorist incidents and countries will be discussed, including organizational differences in healthcare, varying political histories with regards to terrorism, and differences between the attacks themselves and the affected populations. This comparative case study will provide a better understanding of the complexity of policy responses to terrorist attacks across countries, as well as challenges and opportunities for research and health management of such disasters.

Paper 2: Stress Reactions in the Population after Terrorist Attacks

Co-authored quantitative paper utilizing mortality data from causes of death registries in Norway and France. In planning. I will be the first author, with up to six co-authors (exact number to be decided).

When measuring human consequences and the severity of terrorist attacks, attention is often focused on the quantification of fatalities (Calle & Sánchez-Cuenca, 2011). As much as this gives

an overall picture of the human cost of terrorism that can easily be compared across different attacks and countries, it leaves out important parts that arguably are of importance, both for our understanding of the human costs of terrorism, but also for political responses to it. Health consequences besides physical injuries, and also beyond the ones observed in those directly affected by the attacks, may remain underreported, and failing to account for this may leave us with a simplistic understanding of the ways in which terrorism affect the general population and public health, and thereby societies in general.

Several studies have found that terrorist attacks are followed by reactions of fear, insecurity, and stress in the population (see e.g. Makkonen et al., 2020; Thoresen, Aakvaag, Wentzel-Larsen, Dyb, & Hjemdal, 2012). Furthermore, changes in attitudes and behavior after acts of terrorism have been linked to these reactions (see e.g. Das, Bushman, Bezemer, Kerkhof, & Vermeulen, 2009; Enjolras et al., 2019; Giroux, 2002; Makkonen et al., 2020). However, uncertainty remains about whether and how post-terror stress reactions manifest themselves in the population and how universal these reactions are, or whether the population for instance can get 'desensitized' to a terror threat (Peleg, Regens, Gunter, & Jaffe, 2011). A previous study from Norway found that health concerns associated with stress reactions, such as heart attacks and suicides increased in the general population in the immediate aftermath of terrorism (Strand, Mukamal, Halasz, Vatten, & Janszky, 2016). A later study from France, however, had the opposite findings when studying heart attacks in the population post-terror (Chatignoux et al., 2018). A challenge with these and other previous research on stress reactions in the population after terrorism, is that they mainly consist of case studies focusing on single events, utilizing different methods that make them unsuited for comparison. Beyond the methodological challenges associated with this, single-event studies will also not be able to take into account the variation that exist in terms of how often countries experience acts of terrorism. Not surprisingly, studies have found that countries experiencing repeated attacks might see different reactions to the attacks, both politically, but also in terms of how the public is reacting, as compared to countries with only isolated incidences of terrorism (Schaefer, 2006; Solheim, 2019). Attempting to generalize from existing studies can thus be problematic, both because similar phenomena are measured differently across studies, but also because we try to compare the consequences of rather different events and different contexts.

In an attempt to fill this gap in literature, the focus of this paper will therefore be to study whether terrorism is associated with an increase in a potentially stress-induced health concerns, including cardiovascular disease and suicides, in the general population. To account for cross-country and cross-attack variation, we will study the aftermaths of three terrorist attacks in France in 2015 and 2016, and one in Norway in 2011.

In an attempt to tap further into the underlying mechanisms, the study will look into whether factors such as geographic proximity to the attacks and demographic characteristics appear to affect stress reactions, and how it develops with the passing of time.

Data to be used are mortality data (Causes of death registries in Norway and France), more specifically records of deaths due to cardiovascular disease or suicide. Following Strand et. al (2016) we will measure "the effect" of the terrorist attack at different time points in the aftermath: at 3 days, within the first week, and within the first 4 weeks after the attacks.

Following Chatignoux et al. (2018) we will use two steps and multivariate regression models to evaluate if crude observed variations were related to the attacks, meaning that it was significantly different from the background rate. This method enables a better evaluation of whether changes are indeed related to the terrorist attacks, or if they for instance are due to

other changes, natural fluctuation etc. We will compare to a reference period of 5(?) years prior to the attacks.

Due to legal restraints, it is not possible to merge the Norwegian and French data, but we will perform identical analyses on both datasets to enable the comparison.

To study geographic proximity to the attacks information of place of death/place of residence of the diseased will be used. In France this would imply looking at differences between Paris, or the region Ile de France, for the 2015 attacks/ Nice, or the region Provence-Alpes-Côte d'Azur, for the 2016 attack, and the rest of the country. In Norway this would imply looking at differences between the "Oslo area" versus the rest of the country. There are too few inhabitants in Oslo municipality alone for us to be able to do all the analyzes required. A possible solution to this challenge is to expand the population included in the (aggregated) analysis to include those municipalities that are included in "Byregion Oslo". This region is defined according to the population's interaction patterns, meaning that a significant share of the work force in this region is commuting daily to the center (Oslo) for work and hence can be argued to have a stronger connection to the city than inhabitants elsewhere in the country.

To account for demographic characteristics we will control for age and gender.

Paper 3: Trust after Terror: Institutional trust among young terror survivors and their parents after the 22nd of July terrorist attack on Utøya island, Norway

***Nilsen**, Thoresen, Wentzel-Larsen, and Dyb (2019). Published in Frontiers in Psychology*

Co-authors: Siri Thoresen, Tore Wentzel-Larsen and Grete Dyb

Quantitative paper utilizing interview data from interviews with survivors from the Utøya terrorist attack and their parents, as well as population data from the Norwegian section of the European Social Survey.

Summary:

In the aftermath of terrorist attacks and disasters, public institutions play an important role in re-establishing safety and justice. However, little is known about the importance of institutional trust for victims' potential for healing in the aftermath of mass trauma. This study examines levels of post-terror trust in the police and in the justice system among young survivors from the 2011 Utøya terror attack and their parents. Furthermore, it investigates how institutional trust develops over time among directly affected populations, and whether it is associated with psychological distress. 325 survivors and 463 parents were interviewed face-to-face at wave one (4-5 months post-terror) and 285 survivors and 435 parents at wave two (14-15 months after the terrorist attack). Levels of institutional trust in victims were compared to general population data from the European Social Survey adjusted for age, gender and ethnic background. Measures included trust in the police and justice system, post-traumatic stress reactions, anxiety and depression, and quality of life. Trust in the police among survivors and parents was higher than or comparable to trust levels in the general population at wave one, but decreased for survivors and parents at wave two. Trust in the justice system was higher among those directly affected than in the general population, and increased from wave one to wave two. Levels of institutional trust were negatively associated with distress for survivors in both waves and for parents in wave two. Levels of institutional trust were positively associated with perceived quality of life in parents and survivors. Directly affected groups' institutional trust differed from that of the general population following the terrorist attack, although being directly affected did not

necessarily imply weakened institutional trust. This study found trust to be institution specific, however, trust in institutions changed with time, and the passing of time might be an important factor in better understanding whether trust will generalize across institutions or not. Institutional trust was negatively associated with psychological distress. This finding highlights the potential for institutions to create a healing post-disaster environment.

Paper 4:

For this paper I am still figuring out which alternative plan to go for.

Alternative 1:

Co-authored quantitative paper utilizing register data on consultations in the health care system or survey data on satisfaction with the health care system. I will be the first author with up to six co-authors (exact number to be decided). There are some uncertainties regarding whether this paper is feasible due to delays in accessing register data because of high pressure on the registers associated with the current pandemic.

Building on paper 2, we will investigate further whether there appears to be heterogeneity within the population, in terms of whether different groups appear to be affected differently by terrorist attacks, and if so - why. In this paper the intention is to look at reactions among children and youth, by studying the rate of consultations in the healthcare system that can be attributed to stress-related reactions. Children and youth are often overlooked in research on the consequences of conflict and terrorist attacks, as they are mostly considered 'victims' in these circumstances without any social or political agency. However, in both the Utøya and the Nice attacks in particular, children were central victims, and their role as targets needs further scrutiny.

Alternative 2

Co-authored quantitative paper utilizing survey data from two separate surveys of individuals directly and indirectly affected by terrorism. I will be the first author with up to six co-authors (exact number to be decided).

Studying satisfaction with the healthcare system utilizing survey data from directly affected individuals in Norway (The Utøya study) and France (The study after the November attacks), with the potential to compare with data from the general population using data from the European Social Survey.

Alternative 3:

Qualitative paper submitted to BMC Health Services Research.

Co-authors: Lise Eilin Stene, Cécile Vuillermoz, Roel Van Overmeire, Johan Bilsen, Michel Dückers*,* ***Lisa Govasli Nilsen*****, Stéphanie Vandentorren* (*Equal contributions).*

Summary:

Background

The international terrorism threat urges societies to invest in the planning and organization of psychosocial care. With the aim to contribute to cross-national learning, this study describes the

content, target populations and providers of acute and long-term psychosocial care to civilians after terrorist attacks in Norway, France and Belgium.

Methods

We identified and reviewed pre- and post-attack policy documents, guidelines, reports and other relevant grey literature addressing the psychosocial care response to terrorist attacks in Oslo/Utøya, Norway on 22 July 2011; in Paris, France on 13 November 2015; and in Brussels, Belgium on 22 March 2016.

Results

In Norway, target groups were proactively screened and followed up throughout a year within primary care or occupational health services. In France, a network of specialized emergency psychosocial units provided acute psychological support including guidance for long-term healthcare. In Belgium, a reception center was organized to provide acute psychosocial care, but there were no public long-term psychosocial care initiatives in response to the attacks.

Conclusions

Psychosocial care responses, especially long-term follow-up activities, differed substantially between countries. Models for registration of affected individuals, monitoring of their health and continuous evaluation of countries' psychosocial care provision incorporated in international guidelines may strengthen public health responses to mass-casualty incidents.

Paper 5: The securitization of health in the aftermath of terrorist attacks

Qualitative paper, which will utilize the same policy documents as paper 1. First round of document analysis completed.

The plan for this paper is to study the extent to which, and if so how, health care measures are securitized in the aftermath of terrorism. More specifically, by evaluating how security measures are integrated into healthcare provision after terrorist attacks.

The state's role as a provider of psychosocial well-being in the population on the one hand, and security on the other, can be closely linked (Pupavac, 2005). The influx of theoretical directions such as critical security studies (see e.g. Nunes, 2018) and human security (see e.g. Ostergard Jr. & Griffin, 2018) have enabled us to better theorize about the interconnections between health and security. In a broader scope, certain global health problems, such as for instance AIDS and other epidemics, not to mention the current COVID pandemic, have in recent decades been understood not only as global health problems, but also as global security threats (Ooms & Hammonds, 2018). In this understanding of security, a central tenant is the population's security, as this is perceived as a vital part of overall state security, given the population's role in providing state capacity, including for economy and governance (Ostergard Jr. & Griffin, 2018). A state's ability to handle threats to its population, including their lives and health, and to its territories is in turn dependent on its institutional, technical, administrative, and political capacity (Ostergard Jr. & Griffin, 2018). Although these capacities may be difficult to observe empirically, as pointed out by Ostergard Jr. and Griffin (2018), studying policy processes could give an increased understanding of how these capacities express themselves and lead to political operationalization.

In addition, the securitization of certain events may affect the policy processes following these events and the evaluation of what measures are seen to be appropriate and acceptable to the

state and its population. In other words, "...security is political not simply because it originates from political processes of interpretation, but also because it alters political priorities, helps to legitimize certain practices, and contributes to defining the range of acceptable and desirable policy options in a given situation" (Nunes, 2018, p. 3). This means that when a situation is securitized, as terrorist attacks typically are, this could affect the nature of policy processes implemented. Seeing measures to provide health and security in connection with each other could therefore be an important part of broadening our understanding of the policy actions available to a state's authorities, and the measures expected by the population, in the wake of a terrorist attack.

The research questions to be studied are the following:

1. To what extent and in what ways is the securitization of health care palpable in health contingency plans in Norway and France?
2. How can this be understood in relation to the overall securitization of the terrorist threat in the two countries?

A brief summary of progress so far

My PhD period started April 2019. I was on parental leave from April 2020-February 2021. Progress in the dissertation work this far has mainly been focused around the following:

Coursework

- 2019: International Comparison of Health Care Systems at the NIHES, Erasmus MC University in Rotterdam.
- 2021: SFEL8000 (Philosophy of Science for the Social Sciences)
- 2021: ECPR Virtual Methods Summer School hosted by Katholieke Universiteit Leuven, more specifically the courses "Case Study Research: Method and Practice", "Applied Regression Analysis: Estimation, Diagnostics, and Modelling", and "The Statistics of Causal Inference".

Data collection, preparation, and ethical approvals

Documents to be analyzed for papers 1 and 5 have been collected in full and initial processing is finished for both papers, whereas the full analysis is completed for paper 1 only. Access to, and initial processing of, the register data is an ongoing process, where the project group currently is working on the mortality data (causes of death registries). As the systems in Norway and France are different from one another, both in terms of how we can access the data, but also in some instances when it comes to how data are recorded, this is a timely process. Furthermore, these registers are produced for administrative rather than research purposes, and processing of the data prior to utilizing them for research purposes is hence paramount. Access to all survey data necessary for the project has been secured, with data for paper 3 being readily analyzed, whereas the data for paper 4 awaits analysis.

Since the project handles health care data it depends upon approval from REK (Ethical Committee for Health Research). This has been secured, but one further approval is pending since the data utilized in paper 2 (as well as other papers in the overall project), report on causes of death that are relatively rare, leading to challenges concerning anonymization.

Papers

Paper 1 is at the editing stage, and the intention is to submit it to the journal "Disasters: The Journal of Disaster Studies, Policy and Management" in the fall of 2021. This paper was presented at the Northern European Conference on Emergency and Disaster Studies in September 2021. It has also been presented at internal seminars at NTNU (April 2019) and NKVTS (May 2020). Paper 2 is in planning, with the analytical framework being developed at the moment, but full access to all required registry data is still pending due to the need for one further ethical approval, as described above. Paper 3 is completed and published. Paper 4 is still at the idea stage. Paper 5 is at the stage of initial analysis.

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