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The Oslo Pride Terror Study: you don't always know what you need

PERSPECTIVES

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Three years after the terrorist attack during Oslo Pride, those affected report post-traumatic stress reactions and unmet support needs.

In the early hours of 25 June 2022, around 600 people in Oslo were caught up in a terrorist attack while at work or out celebrating Pride and the summer. The terrorist's aim was to 'kill as many queer people as possible (...) and instil fear in queer people' and in society at large (1). Although some people were more directly exposed than others, the court determined that everyone present was a potential target and that it was mostly random who ended up being shot (1).

The response to the terrorist attack was managed at a local level, without a centre being established for evacuees and their families or specific measures being initiated for psychosocial follow-up for those affected (2). As per national

guidelines, follow-up was to be carried out in the municipality where the person in question lived (3). For Oslo local authority, this entailed responsibility for more than half of those directly affected. The large number of people impacted, combined with the absence of a clearly defined target group for proactive follow-up, may have overwhelmed local services and made it difficult to prioritise, allocate resources and implement practical support measures.

> ***«The large number of people impacted, combined with the absence of a clearly defined target group for proactive follow-up, may have overwhelmed local services»***

In 2024, the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) was commissioned by the Ministry of Justice and Public Security to conduct the Oslo Pride Terror Study (called *25. juni-studien* in Norwegian), which is a national study examining how policy measures and societal responses following the 25 June 2022 terrorist attack in Oslo have influenced identity, support needs and democratic engagement among those affected (4). A total of 229 individuals (38 %) who were present during the terrorist attack participated in the study. Two out of three participants are men, and 62 % identify as queer. In the study, as in the court ruling (Oslo District Court, 2024), the term 'queer' is used as an umbrella term for individuals who identify as lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ+).

Many have an unmet need for support

Two people were killed in the attack, nine sustained non-fatal gunshot wounds and many suffered minor injuries amid the ensuing chaos. More than half witnessed someone being injured or killed. Around two-thirds reported a fear of being killed or seriously injured, or feeling trapped without any means of escape. A few even risked their lives by overpowering the attacker. Most were worried about the safety of friends or family members (4).

Almost three years after the terrorist attack, 53 % of those affected say they have returned to their previous level of functioning. The remainder still require support, and one in four report unmet needs, mainly related to post-traumatic stress reactions and associated health problems (4).

As part of the study, participants with unmet support needs received an individual summary of their own responses. This summary can be used when engaging with support services to facilitate access to appropriate care.

Post-traumatic stress reactions and other health problems

The experiences and reactions of those present during terrorist attacks and other disasters are key risk factors for post-traumatic stress disorder (PTSD) (5, 6). As expected, the Oslo Pride Terror Study also found that a higher degree of exposure to risk to life during the attack was associated with higher levels of post-traumatic stress reactions three years later (4). Approximately 20 % reported symptoms consistent with PTSD. Increased symptoms of PSTD were linked to greater functional impairment and a higher risk of unmet support needs.

Many also reported related health problems such as anxiety and depression, sleep disturbances, headaches or other types of pain (4).

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Patients with PTSD can benefit considerably from trauma-focused therapy, and comorbidities should be treated with targeted interventions (7). Since comorbidity is often the rule rather than the exception, it is particularly important that healthcare personnel are aware that post-traumatic stress reactions may be the underlying cause. This awareness can help ensure access to appropriate and effective support.

Proactive support is crucial

Those directly affected often require follow-up in both primary care and the specialist health service (8–10). However, research from previous terrorist attacks and disasters, both nationally and internationally, shows that many do not receive adequate support (11–14). A key challenge is that many people – often those with the greatest need – delay or avoid seeking help, or drop out of therapy (7, 8, 10). This is particularly concerning because early intervention is associated with a reduced risk of chronic and severe psychological symptoms (15).

Evidence on the effectiveness of psychosocial interventions after disasters is limited (16), and national and international guidelines are largely based on expert consensus (3, 17). These guidelines recommend early and proactive follow-up, where a dedicated contact person monitors the affected individual over time, assesses needs and offers support when necessary (18). The aim is to (re)establish a sense of safety and functioning, and to ensure early access to low-threshold services and treatment, in line with the principle of the lowest effective level of care. Mobilising and strengthening support from close personal networks is a core component of this, as social support is the most important protective factor against post-traumatic stress and plays a key role in improving treatment outcomes (7, 19, 20).

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No established system for psychosocial follow-up

Those affected by the 2022 terrorist attack came from all over Norway. Norwegian local authorities, together with primary care and the specialist health service, are responsible for psychosocial emergency preparedness following crises. Most local authorities now have a psychosocial crisis team, but there is no national standard for how to structure these services (3). Experiences from the 22 July terrorist attack revealed considerable local variation in the service provision, as well as challenges related to cross-sector collaboration and coordination (19).

'No pro-active approach'

Almost half reported an unmet need for health care or ineffective care, with most highlighting the lack of proactive follow-up from the health service. One participant identified systemic issues, including the failure to register those affected and the lack of communication between agencies. They noted that these problems have not improved, despite the experiences from the terrorist attack on 22 July 2011:

'*(...) was truly shocking, and we had exactly the same experiences as those from 22 July, the trauma from the terror attack remained, even 11 years later, there was no improvement in healthcare follow-up, in the system, or anything else, there were no systems registering all of us, no one knew who was registered, who was traumatised, or who had been exposed to terror, there were no comprehensive systems, no proactive approach as they claim to have, (...) and it's extremely frustrating.*'

'You don't always know what you need'

Others said that it was difficult to contact support services themselves because, for example, they lacked the energy and/or had a tendency to downplay their own reactions. Some felt that others' need for help was greater than their own and they did not want to take resources away from them. Others said they did not know who to contact or what kind of help they needed. One participant described it as follows:

'*(...) and especially what you need, you don't always know what you need... or at least what kind of help is available, and what's acceptable, it would have been nice... someone you could call who knew and could help you move forward, and maybe also followed up a bit, because despite all the phone calls I made trying to get help, there was still never any mention of follow-up, I mean, over time.*'

Several expressed understanding that this was a major event, affecting many people. One person described it as follows:

'*I completely understand that there was a large number of people affected here, so it was difficult to keep track. And of course, I get that it's hard to call [several hundred] people, but I think that in the situation I was in, and many others say the same; that first step of picking up the phone to call some crisis line or something like that, it's a big one. So I don't know if it's too much to expect, but if someone had called me and said, "Hi, we know you were there, we know you might need some support, here's an opportunity, come to us, we'll set up an appointment...", anything, really. Just not having to take the initiative myself, it might be asking too much, but I think it would have been incredibly helpful.*'

'I needed acceptance'

Among the participants who commented on which services they had found particularly helpful in the time after the attack, healthcare services were mentioned most often, especially the mental health service, but also general practitioners and crisis teams. Among those who reported substantial benefit from talking to a psychologist, around half had received care from the private sector or through health insurance. One person said:

'*(...) And I quickly realised that I needed to do something about this, so I contacted a private psychologist, actually, I did. To get help quickly, and I got an appointment very fast, and that has been very helpful for me. (...) And what I probably felt, what helped me then, was getting confirmation that, because I tend to think, "Oh come on, I should be able to deal with this", but the fact that the psychologist said, "What you've been through is actually quite traumatic. It's natural to have a reaction to it". And I needed that acceptance, which I got there.*'

Some mentioned that they had received proactive support from a crisis team:

'It was the conversations with the crisis team (...) They contacted me. At a time when I didn't even know if I needed to call anyone. And that... I needed help, but I never would have taken the initiative to make that call.'

Psychosocial follow-up as an integral part of emergency preparedness

Reaching those who do not initiate contact with support services or express a need for help is a recognised challenge after crises and disasters. Nevertheless, proactive psychosocial follow-up is not currently an integral part of the emergency preparedness and response, which contravenes the fundamental principle of needs-based and equitable health care, as enshrined in health legislation and national guidelines. This is a gap that can and must be closed.

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