LIVING LITERATURE REVIEW | VERSION 3.1 | 24 AUGUST 2026

Ontological Shock, Existential Destabilisation and Ontological Resilience

A living literature review: application to UAP / NHI disclosure preparedness, public health planning, and Australian Health Needs Assessment design

Prepared for	Preparing Australia Campaign
Prepared by	Michelle McAllister
This version	Version 3.1 (Living Document), 24 August 2026 (AEST). Adds organised experiencer-support infrastructure and organisational survey research (MUFON; UFO Research Queensland).
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Status	LIVING DOCUMENT. Working evidence base under active development as part of a co-design process. This version has not been through any broader consultation process and is not a final document. It is offered as a starting resource: what the literature currently says, how it is categorised, and which perspectives are not yet adequately represented.

What a living document means here. This review is an emerging piece of academic infrastructure, built in the open and versioned. It holds evidence-informed perspectives at labelled tiers, records its own gaps explicitly, and is designed to receive contributions, from professional bodies, researchers, clinicians, traditional owners and knowledge holders, culturally and linguistically diverse communities, and people with lived experience, through a co-design process. Each version carries a change log. Nothing in it should be read as settled; everything in it should be read as offered for testing.

Contents

Purpose and Evidence Status

What this review is

This review maps what is currently known, and currently argued, about ontological shock and existential destabilisation, with specific application to preparedness for Unidentified Anomalous Phenomena (UAP) and Non-Human Intelligence (NHI) disclosure scenarios. It is written for colleagues in psychology, psychiatry, public health, primary care, emergency management and health service planning, and for the parliamentary and departmental readers who will decide whether Australia examines this before it has to.

It is offered as a working document and as an invitation. Where the evidence is strong, we say so. Where it is emerging, we say that too, and we keep it, because a field in motion is not a field to be excluded from.

Why now

Formal evidence lags a moving discourse. That is an ordinary condition of preparedness work rather than a peculiarity of this subject. The same lag applied to pandemic psychosocial planning, to disaster mental health, and to climate-related distress. In each case the professions did not wait for the literature to settle before beginning to plan. They built frameworks capable of holding uncertainty, and refined them as evidence arrived.

The question here is narrower than the public conversation and more practical. It is not whether disclosure will occur, when, or what it would mean. It is this: if a profound disruption to shared understanding occurred, would Australian services know what to expect, whom to prioritise, and how to communicate? That question has not been asked systematically in this country. This review sets out the evidence that would inform it.

How to read the evidence

The review draws on peer-reviewed empirical research, peer-reviewed conceptual and clinical work, preprints and conference material, and organisational, archival and unpublished sources. Each is labelled for what it is, and the reader is asked to weigh it accordingly.

That labelling is deliberate, and it is not a hedge. Emerging material is included because it is where the current thinking lives. It is tiered because a colleague is entitled to know what they are being handed. Nothing here asks anyone to treat a preprint as a finding, or a survey of self-selected respondents as population prevalence. What it asks is that emerging work be read as emerging work rather than set aside, which is the same standard any of us would want applied to our own field before it matured.

The discipline and the openness are the same act. Labelling the evidence honestly is what makes it possible to bring emerging work into a policy conversation at all.

What we are asking of colleagues

Test it against your practice. If the framework does not match what walks through your door, that is the most useful thing you can tell us.

Tell us where we have overstated. If any claim here reads as stronger than its evidence supports, we would rather hear it now than have it found later.

Bring your profession’s existing position. Where a college, society or network has already taken a view on preparedness, planning or psychosocial response, it belongs in this review and we will cite it.

Add what is missing. Australian and New Zealand work in particular, Aboriginal and Torres Strait Islander perspectives held by traditional owners and knowledge holders, culturally and linguistically diverse community perspectives, and contemporary lived-experience perspectives. See Part Three for what this version knows it does not yet hold, and Part Four for how contributions enter the document.

One observation still open

The review notes that no Australian Health Needs Assessment for these scenarios was identified in the sources reviewed. That is the one statement in this document which is not evidence of something, but the absence of something, and an absence can only be supported by showing where one looked.

A reproducible search appendix (Appendix A) records the databases, search terms, dates, limits and inclusion criteria behind that observation, most recently re-tested on 20 August 2026. Relative to the databases not yet searched, which Appendix A names, the observation remains open to correction.

And we would be glad to be wrong. If such an assessment exists, the single most useful outcome of circulating this review is that somebody tells us so.

Evidence Tiers Used in This Review

Evidence tier	How it is used
Tier 1: Peer-reviewed empirical research	Empirical journal articles using qualitative, quantitative, survey, mixed-methods, or longitudinal designs. Examples include Lomas, De la Torre, Argyri et al., Evans et al., Irwin, and Harms et al.

Evidence tier	How it is used
Tier 2: Peer-reviewed conceptual, theoretical, or clinical literature	Peer-reviewed clinical and theoretical work that provides conceptual tools but does not directly measure disclosure response. Examples include Rabeyron, Park, Janoff-Bulman, Terror Management Theory, Rose, Giddens, Laing, and Tillich.
Tier 3: Preprints and conference material	Material in scholarly circulation that has not completed peer review, including concept papers, modelling papers, and conference presentations. Examples include Priestland, De la Torre, and Lomas (2026) and De Foe's forthcoming 2026 conference presentation.
Tier 4: Organisational, evidence-informed, archival, and unpublished material	White papers, foundation reports, government and institutional documents, public-interest research, and unpublished manuscripts. Examples include uNHIdden Foundation reports, the Disclosure Foundation report, FREE Foundation survey material, and Basterfield's 1997 unpublished manuscript if held or archivally confirmed.

Key Source Handling Summary

Source	Tier	Handling
Lomas (2025)	Tier 1	Use as exploratory peer-reviewed analysis of social-media responses. Do not present as representative population or service-demand evidence.
De la Torre (2024)	Tier 1	Use as sample-level survey evidence on witness psychological impact and deep engagement. Do not present as population prevalence.
Priestland, De la Torre, and Lomas (2026)	Tier 3	Retain as directly relevant preprint and modelling concept paper. Label as not peer reviewed and avoid treating projections as measured demand.
uNHIdden (2024, 2026)	Tier 4	Retain as evidence-informed policy and clinical preparedness material. Cite separately from peer-reviewed studies.
Disclosure Foundation (2026)	Tier 4	Retain as organisational white paper, especially where it converges with peer-reviewed literature.
Argyri et al. (2025)	Tier 1	Use as peer-reviewed qualitative evidence on psychedelic-related existential distress and integration.
Evans et al. (2023)	Tier 1	Use to describe extended difficulties in a self-selected affected sample. Do not call it base-rate evidence.
Rabeyron (2022)	Tier 2	Use as clinical framework for anomalous-experience counselling and clinician preparedness.
Basterfield (1997)	Tier 4	Use only with careful unpublished-manuscript note and source-location footnote if a copy is held.
De Foe (2026)	Tier 3	Describe as forthcoming conference presentation unless a formal paper becomes available.

Part One: International Research Landscape

1.1 Conceptual Origins: Where the Term Comes From

The intellectual genealogy of ontological shock runs through clinical psychiatry, existential philosophy, sociology, and anomalous-experience research. The term is now being used in UAP and disclosure preparedness discussions, but its conceptual roots are older and broader.

R. D. Laing (1960) introduced the concept of ontological security and ontological insecurity in The Divided Self, originally as a clinical framework for understanding schizoid and schizophrenic states. For Laing, ontological insecurity described the experience of a person whose sense of identity, continuity, embodiment, and reality was not

reliably grounded. The relevance here is not diagnostic. It is structural: Laing gives language for what happens when the foundations of reality-sense fail.

Paul Tillich (1952), in The Courage to Be, described existential anxiety as arising from the threat of non-being, meaninglessness, death, and groundlessness. This philosophical and theological lineage matters because ontological shock is not merely a cognitive error or an information deficit. It can activate spiritual, moral, cosmological, and existential frameworks at the same time as psychological ones.

Anthony Giddens (1990, 1991) gave ontological security a sociological register. He described it as the confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity. Giddens located this security in routines, biographical narrative, and trust in institutions. This is especially important for public health planning: when ontological security is disrupted at scale, the destabilisation may be institutional as well as individual. If institutions are perceived to have concealed, mishandled, or inadequately explained a reality-changing matter, they may become part of the distress mechanism rather than only part of the recovery mechanism.

John Mack (1994) was the first major clinical researcher to apply ontological shock explicitly to alien-abduction and UAP-adjacent experience. In Abduction: Human Encounters with Aliens, Mack treated many experiencers not as simply pathological cases, but as people undergoing a profound reality-disruption that could not be integrated within their prior frameworks. Mack's patient-centred approach remains significant because later models, including uNHIdden's clinical framing and Rabeyron's CIRCEE work, similarly emphasise non-dismissive engagement, integration, and meaning-making.

1.2 The UAP-Specific Research Literature

Lomas (2025): Social-media responses and ontological fracturing

Tim Lomas produced a peer-reviewed exploratory analysis of social-media responses to the July 2023 Congressional UAP hearing, an event interpreted by some participants as disclosure-like. The article was first published online in 2024 and appeared in Journal of Humanistic Psychology in 2025. Using grounded theory analysis of posts on X, Lomas identified 19 themes, 76 subthemes, and four broad response categories: concern, positive reactions, scepticism or indifference, and critical engagement.

The central value of the paper is that it challenges a simplistic mass-panic model. Rather than demonstrating a single collective shock, it documents a heterogeneous response field. Lomas proposed ontological fracturing as a more precise descriptor for situations where previously stable assumptions develop cracks requiring gradual reinterpretation and integration. For public health planning, the implication is cautious but important: future disclosure-related distress is likely to be unevenly distributed. The study does not measure clinical distress, population prevalence, or service demand, but it does provide an empirically grounded typology for designing future population research.

De la Torre (2024): Psychological aspects in UAP witnesses

Gabriel G. De la Torre's survey in International Journal of Astrobiology examined 245 participants, including 93 direct UAP witnesses. The study identified a pattern he termed the UAP deep psychological engagement triad: the topic being present in a witness's mind daily, a self-recognised interest and appreciation for the topic, and a need to talk about UAP extending beyond the specific event experienced.

The study supports the view that UAP witnessing can be psychologically significant, transformative, and not necessarily pathological. Its value is that it supplies quantitative and qualitative sample data that complements Mack's clinical observations. It should not be described as population-level prevalence evidence. It is sample-level survey evidence, and its findings require replication across cultural contexts, including Australia.

Priestland, De la Torre, and Lomas (2026): Health Needs Assessment preprint

Priestland, De la Torre, and Lomas (2026) is the most directly relevant published conceptual and modelling paper identified for applying health needs assessment principles to disclosure preparedness. It is a Preprints.org concept paper, DOI 10.20944/preprints202605.1417.v1, and should be treated as emerging methodological work rather than validated epidemiological evidence.

The preprint applies public health emergency preparedness and health needs assessment logic to hypothetical disclosure scenarios. It uses scenario-based structured expert elicitation, constructed demographic groups, and population extrapolation to explore potential support requirements. The authors frame the work in relation to active

public and governmental UAP disclosure processes and argue that confirmation of NHI could trigger clinically meaningful distress in a subset of the population.

Its strongest contribution is not the precision of its projected numbers. Its strongest contribution is methodological: it shows how disclosure preparedness can be translated into health needs assessment questions, including vulnerable groups, support tiers, surge capacity, professional training, community support, and communication infrastructure. Its limitations must travel with it: the estimates are hypothetical, culturally limited, sensitive to overlapping population categories, and not direct measurements of future demand.

uNHIdden Foundation (2024): White paper on exceptional experiences and wellbeing

The uNHIdden Foundation's 2024 white paper, The Impact of Exceptional Experiences and Disclosure on Mental Health and Wellbeing, is organisational grey literature with direct policy relevance. It is not peer-reviewed empirical evidence. It is still important because it brings lived experience, clinical concern, stigma reduction, and preparedness into a health and social-care frame.

The white paper's verified headline recommendations are: government acknowledgement of UAP sightings and exceptional experiences; guidance for health and social-care professionals; credible public information and responsible media reporting; multidisciplinary research into likely disclosure reactions and vulnerable groups; and a whole-of-government and community disclosure plan centred on trust and wellbeing. Those recommendations are directly translatable into Australian health-system questions, including PHN commissioning, GP and psychologist training, crisis-line preparation, and community peer-support pathways.

uNHIdden Foundation (2026): Public health preparedness report

Preparing for Disclosure: A Public Health Framework for Paradigm-Shifting Revelations, published by uNHIdden in June 2026, is best described as evidence-informed organisational grey literature. It applies pandemic preparedness, disaster mental health, and crisis communication frameworks to paradigm-shifting disclosure scenarios. Its value lies in policy translation, not in being a peer-reviewed prevalence study.

The report's most useful features for the Preparing Australia campaign are its precautionary register, its focus on preparation rather than proof, and its distinction between population-wide resilience and targeted support for groups likely to experience stronger distress. It identifies potential high-risk groups including committed sceptics, religiously devout communities, existing experiencers, and people with pre-existing mental health vulnerability. These categories should be treated as hypotheses for Australian testing rather than settled demographic facts.

Disclosure Foundation (2026): Psychological impact report

The Disclosure Foundation's 2026 report, The Psychological Impact of UAP/NHI Disclosure, is a research-informed organisational white paper. It is useful because it converges with Lomas and uNHIdden on a key preparedness point: the principal public-health risk is less likely to be undifferentiated mass panic than concentrated strain on mental health, crisis-support, community-trust, and information systems.

The report should be cited as organisational analysis rather than peer-reviewed empirical evidence. Its role in the review is to support policy preparedness and stakeholder mapping, especially where it aligns with peer-reviewed or clinical literature.

1.3 Psychedelics as an Analogous Model

A significant body of empirical research on psychedelic-induced ontological disruption has emerged as a useful analogue. The analogy should be handled carefully. Psychedelic experiences and UAP/NHI disclosure are not the same phenomenon, and no cited study directly compares their mechanisms. The psychedelic literature is relevant because both fields contain reports of destabilised assumptions, altered self-experience, existential uncertainty, and prolonged meaning-making. Whether the underlying mechanisms are comparable remains an empirical question.

Argyri et al. (2025), in PLoS ONE, conducted a qualitative interview study with 26 people who reported existential distress following psychedelic experiences. The study found persistent existential struggle, confusion about existence and purpose, preoccupation with meaning-making, and a liminal state marked by disorientation from prior knowledge and openness to new ways of seeing. Participants reported that grounding, embodiment, social support, cognitive normalisation, and non-pathologising frameworks were helpful. They described lack of understanding, inadequate integration support, obsessive searching, imposed spiritual interpretations, and in some cases further substance use as unhelpful. Meditation had mixed effects.

Evans et al. (2023) conducted a mixed-methods study of 608 participants who reported extended difficulties after psychedelic experiences. Common difficulties included anxiety and fear, existential struggle, social disconnection, depersonalisation, and derealisation, with duration ranging from weeks to years. This study does not provide base-rate data, because participants were recruited on the basis of already having extended difficulties. Its value is descriptive: it characterises the forms and duration of difficulty among a self-selected group who reported problems.

For disclosure preparedness, the psychedelic literature supports a practical design principle: when an event destabilises a person's reality-framework, recovery may require grounding, coherent language, shared experience, skilled listening, and support that neither dismisses the experience nor forces a single explanatory frame. This is directly relevant to clinician training, peer-support design, and public communication.

1.4 Clinical Frameworks for Anomalous Experience

Rabeyron (2022) provides one of the strongest clinical frameworks for anomalous experience. The article, When the Truth Is Out There: Counseling People Who Report Anomalous Experiences, describes the Centre for Information, Research and Counselling about Exceptional Experiences (CIRCEE), developed in France from 2009. At the time of publication, approximately 1,000 people had contacted the service and more than 750 had received counselling. The paper also reports approximately 450 therapies between March 2016 and March 2021, or about 90 per year.

Rabeyron's key contribution is the clinical insight that ontological disruption does not affect only the experiencer. Clinicians themselves may experience defensive rejection or secondary ontological shock when a patient's account contradicts the clinician's own conception of reality. This has direct implications for Australian preparedness. It is not enough to create public messaging. Clinicians, crisis-line workers, peer supporters, and community health staff need training that enables them to hear anomalous narratives without premature judgement, pathologisation, forced belief, or forced disbelief.

Rabeyron proposes Psychodynamic Psychotherapy focused on Anomalous Experiences (PPAE) and emphasises the therapeutic importance of allowing anomalous experiences to be narrated and explored without premature judgement or forced explanatory closure. The Australian application would not need to copy CIRCEE in full. It would need to translate its core clinical lessons into Australian service settings, including general practice, psychology, psychiatry, crisis lines, PHNs, Medicare Mental Health Centres, and community-led support.

The FREE Foundation survey material is potentially relevant because it reports large-scale experiencer perspectives and suggests that contact experiences may be interpreted as positive, transformative, or meaningful by many respondents. However, the frequently circulated figures, including telepathic communication, net positive effects, and not wanting contact to cease, should not be used as primary academic evidence unless the full report, survey version, sample denominator, recruitment method, item wording, and analysis are obtained. In this review, FREE material belongs in Tier 4 as experiencer-organisation survey evidence.

The Mutual UFO Network (MUFON), founded in 1969, is the largest volunteer civilian UAP research organisation and maintains what it describes as the largest civilian case database in the world, with figures in excess of 100,000 reported incidents cited across organisational statements. It publishes a monthly journal and holds an annual symposium. Its material belongs in Tier 4 as organisational and experiencer-organisation evidence, and its case database should be read with a specific discipline: a reporting database is primary evidence of reporting behaviour, of what people experience themselves to have encountered and how they seek to be heard, not primary evidence of the phenomena reported. Read that way, it is one of the longest continuous records available of the population a preparedness framework would serve.

Two MUFON assets bear directly on preparedness. The first is the Experiencer Resource Team, a triage and referral service staffed by field investigators with additional training in compassionate response, which receives experiencers through a structured intake questionnaire and connects them, according to their own preferences, with support groups, psychologists, or investigators who will simply take their report. As with CIRCEE, though at a volunteer rather than clinical tier, the Experiencer Resource Team demonstrates that structured intake for anomalous experience is operationally feasible and that demand for it exists; unlike CIRCEE, no published service data or outcome evidence was identified, and the model carries no clinical governance. The second is the survey research line the organisation has sustained. The Marden-Stoner Commonalities Among Abduction Experiencers study (Marden and Stoner, 2012) surveyed 50 self-identified experiencers and 25 controls on a 45-item instrument and reported 23 shared characteristics; a later, larger Experiencer Survey extended this work. Recruitment was self-selected through MUFON channels, conferences and radio audiences, so the caveat applied to FREE material above applies equally here: frequently circulated findings should not be cited onward as primary academic evidence

unless the full report, sample method and item wording are obtained. The final Marden-Stoner report is publicly available, which makes that verification practical.

1.5 Foundational Psychological Frameworks

Several established psychological frameworks are relevant even though they were not developed for UAP/NHI disclosure.

Janoff-Bulman's shattered assumptions theory provides a trauma-psychology account of how severe events can erode core assumptions about the benevolence of the world, the meaningfulness of the world, and the worthiness of the self. Applied cautiously to disclosure, the most direct challenge may concern the meaningfulness and comprehensibility of the world: a fundamental feature of reality may have been misunderstood, withheld, or excluded from public sense-making.

Terror Management Theory, associated with Greenberg, Pyszczynski, and Solomon, proposes that cultural worldviews buffer existential anxiety. A disclosure-specific hypothesis derived from TMT is that people whose existential security depends heavily on a threatened worldview may display stronger defensive responses, including denial, ideological intensification, or hostility toward perceived outgroups. This remains to be tested.

Park's meaning-making model distinguishes global meaning from situational appraisal. Distress arises when an event's appraised meaning conflicts with global meaning. Applied hypothetically to disclosure, the model would predict that events high in discrepancy from existing global meaning will produce greater distress and longer resolution periods unless assimilation or accommodation pathways are available.

Geoffrey Rose's population-prevention model is relevant because it distinguishes high-risk strategies from population-wide prevention strategies. The application to disclosure preparedness is an analytic extension: if ontological distress risk is broadly distributed, small improvements in population-wide resilience may reduce aggregate burden more effectively than support limited only to the most distressed minority. This should be cited either to Rose directly or to any preparedness report that explicitly applies Rose to disclosure.

1.6 An Emerging International Discourse: Experiential Dimensions and the “Empirical Weird”

This section reports an emerging discourse. Its sources are a research-organisation newsletter (Tier 4) and forthcoming scholarly material (Tier 3). It is included because the discourse is directly relevant to the disciplinary breadth question this review raises, not because its claims are established.

A discourse is visibly forming in the international UAP research community around the experiential and consciousness-related dimensions of anomalous encounters, the dimensions this review approaches through the clinical and public-health literature above.

The Victoria Congress and the SUAPS framing. The X International Congress of Ufology was held in Victoria, Entre Ríos, Argentina in 2026, hosted by Museo OVNI Victoria, with 278 registered participants from seven countries (242 from Argentina, with delegations from Uruguay, Chile, Spain, Peru, Brazil and Colombia), fourteen recorded presentations, and more than thirty researchers and academics. Organisations represented included the Society for UAP Studies (SUAPS), CEFORA, ALAS, Soulwatchers, Visión OVNI, Fénix 4 and Museo del OVNI de La Serena (Corio & Pérez Simondini, 2026; Tier 4 conference report).

The congress report, written for a largely North American readership in the Scientific Coalition for UAP Studies’ publication, records that one of the event’s most distinctive features “particularly from the perspective of North American audiences” was the attention devoted to what SUAPS has termed the **“Empirical Weird”**: recurring patterns of anomalous subjective experience that frequently accompany UAP encounters but fall outside the scope of traditional aerospace analysis. Themes presented under this heading included altered states of consciousness, unusual perceptual experiences, synchronicities, long-term psychological effects, and recurring experiential patterns reported by witnesses. Critically for this review’s purposes, the report is explicit that “these topics were not presented as substitutes for scientific investigation. Rather, many speakers argued that they represent additional categories of data deserving careful examination” (Corio & Pérez Simondini, 2026).

The disciplinary inventory, and what it omits. Congress participants proposed that future UAP studies may require “a broader interdisciplinary framework integrating psychology, anthropology, phenomenology, sociology, and cognitive science alongside physics, engineering, and astronomy.” This is a published, attributable, externally sourced inventory of the fields an international research community considers necessary, arrived at independently

of the clinical and public-health literature reviewed above. Read against this review, the inventory is notable for what it does not contain: public health, health workforce, clinical practice, mental health service design, primary care, and emergency and disaster management. Those are precisely the disciplines the Australian preparedness lane brings. The international discourse has named the experiential problem; it has not yet named the health-system disciplines that would carry a population-level response to it. That absence is the space this review, and the proposed Australian Health Needs Assessment, occupy.

Convergence across communities. The same report describes contemporary Latin American UAP research as characterised by "willingness to engage across methodological boundaries," a transition "from classical ufology toward what many participants now describe as UAP studies," and growing engagement with evidence standards, data management and international collaboration, paralleling developments in SCU, the Galileo Project and European initiatives. The significance for this review is discourse-level rather than evidential: communities working from very different starting points, North American sensor-and-evidence programs, Latin American experiential research traditions, and the clinical ontological-shock literature reviewed in sections 1.2–1.4, are converging on the same recognition, that the phenomenon's experiential dimension is a class of data requiring serious multidisciplinary treatment rather than a category to be excluded. The attendance and organisational breadth at Victoria, and the respectful attention the discourse is now receiving from North American evidence-focused organisations, suggest a banner is emerging under which these previously separate conversations can be reconciled.

Ontological shock enters international-relations scholarship. The same publication reports that Alexander Wendt (Ohio State University), among the most cited living scholars of international relations, has a book scheduled for October 2026, *The Last Humans: UFOs, Global Security, and the Threat to State Sovereignty*, concerned with how nation-states would deal with each other under disclosure conditions. The report's author characterises Wendt as having originally favoured public release of information but having come to the view that "it might be too much of an ontological shock" (Powell, 2026; Tier 4, reporting Tier 3 forthcoming material). Two things follow, at different confidence levels. The book's existence and subject matter are checkable and significant: ontological shock is entering security and sovereignty scholarship, not only psychology. The characterisation of Wendt's change of view is second-hand and unquoted, and is carried here as reported commentary only, pending Wendt's own words in print.

Evidence status of this section. Everything in this section is reported-tier material from a named organisational newsletter and should not be cited onward as primary evidence. Verification pathways: the SUAPS formal definition of "Empirical Weird"; the Victoria Congress recorded sessions (public video archive); Wendt's publisher listing and the book itself on release. The section earns its place not as evidence of the phenomenon but as evidence of the discourse, and the discourse is part of what an Australian preparedness assessment would need to understand, because it shapes what experiencers, clinicians and communities will be reading and saying when they present.

Part Two: Australian and New Zealand Research

2.1 The Australian Anomalous Psychology Research Community

Australia has a small but substantive academic tradition in anomalous psychology and parapsychology, expressed through researchers connected with Australian universities, the Australian Institute of Parapsychological Research (AIPR), and the Australian Journal of Parapsychology. The literature is not yet a disclosure-preparedness literature. Its relevance lies in measurement, worldview, anomalous experience, stress sensitivity, transliminality, and the non-pathologising study of unusual experience.

Harvey Irwin

Harvey J. Irwin, associated with the University of New England and the Australian anomalous psychology research community, is one of Australia's most prolific contributors to the psychology of paranormal and anomalous experience. His work is useful because it treats anomalous belief and experience as psychological and worldview phenomena rather than as simple cognitive deficit.

- Irwin (2017), An assessment of the worldview theory of belief in the paranormal, found that paranormal belief was significantly associated with worldview measures considered collectively in a sample of Australian university students. This supports the importance of worldview structure, although it does not establish worldview as the only or primary predictor.

- Irwin (2018), Stress sensitivity and minimal-self dysfunction as predictors of anomalous experiences and paranormal attributions, used a convenience sample of Australian adults and found that anomalous-experience proneness was associated with stress sensitivity and minimal-self dysfunction, while paranormal attribution was not associated with those variables.
- Irwin (2015), Paranormal attributions for anomalous pictures: A validation of the Survey of Anomalous Experiences, provides methodological support for measuring anomalous attributions.

Taken together, Irwin's work provides useful Australian conceptual and measurement infrastructure for a population study of ontological vulnerability. That is an assessment made for this review, not a finding claimed by Irwin.

Keith Basterfield and Australian UAP experience research

Keith Basterfield, based in South Australia, has been active in Australian UAP research since the late 1960s. His work is important because it links Australian UAP experience reports with psychological interpretation, after-effects, and survey methods.

Bartholomew, Basterfield, and Howard (1991), in Professional Psychology: Research and Practice, considered whether reports of abduction and contact were better understood through psychopathology or fantasy-proneness models. A defensible summary is that the paper argued against assuming psychosis while giving substantial weight to fantasy-proneness as an explanatory framework.

Gow, Lurie, Coppin, Popper, Powell, and Basterfield (2001), Fantasy proneness and other psychological correlates of UFO experience, examined relationships among reported UFO experience, fantasy proneness, paranormal belief, and personality. It should not be summarised as proving that fantasy proneness mediates UAP experience reporting. Its relevance is that it shows an Australian-linked attempt to study psychological correlates without collapsing the question into simple pathology.

The unpublished Basterfield (1997) manuscript, An Analysis of an Australian Survey Questionnaire on the After-Effects of UFO Abductions, should be handled carefully. If a copy is held by the campaign, researcher, or archive, cite it as an unpublished manuscript and include a footnote identifying where the copy is held. Until its methods, questionnaire, sample, and findings are directly reviewed, it should not carry a central research-gap claim on its own.

Thalbourne, Storm, transliminality, and anomalous cognition

Michael Thalbourne (University of Adelaide, 1955-2010) and Lance Storm developed Australian research on transliminality and anomalous cognition. Thalbourne and Storm established the Anomalistic Psychology Research Unit at the University of Adelaide in 2002, operating until 2008. Transliminality, broadly understood as a tendency toward permeability between conscious and unconscious material, is relevant to anomalous experience, creativity, and transformative states.

For disclosure preparedness, transliminality may be relevant to vulnerability, unusual experience, and meaning-making. Whether it also predicts more successful integration remains an open research question. Current Adelaide-linked work on temporal-lobe lability and anomalous cognition should be treated as relevant anomalous psychology research, not as established clinical preparedness evidence.

Alexander De Foe

Alexander De Foe's research focuses on consciousness, out-of-body experiences, and anomalous cognition. The title Dynamic Cognition and Anomalous Experience: A Free Energy Model should be described as a forthcoming 2026 conference presentation, not as a published paper, unless an abstract, proceedings paper, preprint, or journal article is later available. Its relevance is prospective: free-energy and predictive-processing approaches could offer a bridge between anomalous phenomenology and mainstream cognitive science, but the clinical training implications remain to be developed.

Tony Jinks

Tony Jinks is a Senior Lecturer at ACAP University College in Sydney, with work spanning cognitive science, anomalous belief and experience, consciousness, and quantitative methods. His work and professional networks are relevant to Australian capacity mapping, although the literature reviewed here does not identify a direct UAP/NHI disclosure-preparedness study by Jinks.

2.2 Australian Trauma Psychology and Post-Traumatic Growth Research

Australia's trauma and post-traumatic growth literature does not directly address UAP/NHI disclosure. It is still relevant because disclosure preparedness is fundamentally a question of psychological adaptation, meaning-making, community support, and service-load planning under potentially destabilising conditions.

Harms, Molyneaux, Nguyen, Pope, Block, Gallagher, Kavanagh, Quinn, O'Donnell, and Gibbs (2024) studied individual and community experiences of post-traumatic growth ten years after the Australian Black Saturday bushfires. The study found that individual sense of community was a particularly important correlate of post-traumatic growth, although community-level variation was also observed. The preparedness implication is that subjective connection to community may be a key resilience variable, not merely objective community-level indicators.

Phoenix Australia, the Centre for Posttraumatic Mental Health at the University of Melbourne, is Australia's national centre of excellence in post-traumatic mental health. It conducts research, training, and guideline development across sectors including disaster, defence, emergency services, and healthcare. Phoenix Australia should be framed as one potential institutional partner for an Australian Health Needs Assessment because of its trauma-research and guideline-development capability. It should not be described as the only possible or officially designated institutional home without consultation.

Jennifer Wheeler's ANU-linked research on post-traumatic growth among frontline workers is relevant to workforce resilience and occupational exposure. The frequently cited statement that up to three-quarters of Australians will experience at least one potentially traumatic event should be traced to the underlying trauma-prevalence literature rather than treated as established by a scholar profile.

2.3 Australian Public Health Emergency Preparedness

The Australian Disaster Preparedness Framework is a valid national framework for severe-to-catastrophic disaster planning and offers a potentially relevant governance analogue for low-probability, high-consequence preparedness. It should not be presented as a framework that already covers disclosure. No Australian government source reviewed here designates UAP/NHI disclosure as a disaster-planning scenario.

Australian preparedness architecture relevant to a disclosure HNA would likely include the Department of Health, Primary Health Networks, Medicare Mental Health Centres, state and territory mental health systems, crisis-support services, professional colleges, community health organisations, and Aboriginal Community Controlled Health Organisations. Regional health-security work should refer to the Indo-Pacific Centre for Health Security, not an Indo-Pacific Health Security Alliance, unless a separate body by that name is specifically cited.

Claims about perceived coping and terrorism preparedness, NSW Population Health Survey precedents, and health-system-load modelling should be retained only with exact citations. They remain plausible analogues, but they cannot appear as unnamed relevant research in a submission-facing document.

2.4 Recovery-oriented practice and psychosocial support frameworks

Australia already holds a nationally endorsed practice orientation directly relevant to disclosure preparedness. The National Framework for Recovery-Oriented Mental Health Services (Commonwealth of Australia, 2013; Tier 4 national policy framework) commits services to person-led, hope-promoting, strengths-based practice in which people are supported to make meaning of their experience rather than have it pathologised by default. This is the same clinical stance the anomalous-experience counselling literature reaches independently (Rabeyron, 2022): an ontologically destabilised person needs support for meaning-making and integration, not automatic diagnostic reclassification. Recovery-oriented practice therefore provides an existing, auditable, nationally agreed vehicle through which disclosure-related distress could be met inside current service settings, with no new doctrine required.

Psychosocial best practice for population-scale events is likewise already standardised. The Inter-Agency Standing Committee guidelines on mental health and psychosocial support in emergency settings (IASC, 2007; Tier 4 international consensus guidance) structure response as a layered pyramid: basic safety and reliable information for all, community and family supports for many, focused non-specialist supports for some, and specialist services for the few. Australian disaster mental-health arrangements operationalise versions of this architecture (sections 2.2 and 2.3). A disclosure scenario maps naturally onto the same pyramid: calm accurate information at population level, community meaning-making support, focused help where vulnerability concentrates, and specialist care for

the minority experiencing clinical-level distress. The Health Needs Assessment proposed in Part Three would specify that mapping for Australian conditions.

Two Australian research programs supply the planning evidence base. Whiteford and colleagues' burden-of-disease work established the population epidemiology on which Australian mental-health planning rests (Whiteford et al., 2013; Tier 1). The National Mental Health Service Planning Framework, developed under the same research leadership, converts epidemiology into staffed and costed service-demand estimates and is already used by governments and Primary Health Networks for commissioning (Siskind, Harris, Buckingham, Pirkis and Whiteford, 2012, Tier 1 methodology; the framework itself Tier 4 planning instrument). This is the machinery an Australian Health Needs Assessment on disclosure preparedness would run on; nothing needs to be invented.

McGorry's early-intervention and clinical-staging program (McGorry, Hickie, Yung, Pantelis and Jackson, 2006, Tier 2 clinical-conceptual; McGorry et al., 2024, Tier 1 commission) supplies the most relevant service-design precedent: Australia has previously built nationally scaled responses, including early psychosis services and headspace, for emerging and sub-threshold need, ahead of settled diagnostic consensus, on a prevention-and-staging logic. Disclosure-related distress presents the same design problem: heterogeneous, emerging, sub-threshold for many, concentrated for some. The staging logic, the recovery orientation and the psychosocial pyramid together define what prepared would look like in Australian practice terms.

The lived-experience dimension of this architecture is also codified nationally. The National Mental Health Commission's National Lived Experience Workforce Guidelines (Byrne et al., 2021; Tier 4 national guidance) establish designated lived-experience roles, leadership and organisational supports as core mental-health workforce architecture, and the lived-experience leadership literature argues that people with lived experience should hold senior roles across policy, planning, education and evaluation (Byrne, Stratford and Davidson, 2018; Tier 2). The Australian scholarship is consolidated in the Lived Experience Digital Library's leadership collection (livedexperiencedigitallibrary.org.au). The application to disclosure preparedness is direct: experiencers are this domain's lived-experience constituency, and a credible Health Needs Assessment would involve experiencer lived experience in its design and governance on the same principles the national guidelines already mandate for mental health generally, a requirement the experiencer-research literature reaches independently (section 1.2).

2.5 New Zealand

New Zealand's direct contribution to UAP/NHI disclosure preparedness literature appears limited within the sources reviewed. Its institutional and cultural context remains relevant because it shares disclosure exposure as a Five Eyes partner and has strong public-health, mental-health, and emergency-management infrastructure.

He Ara Oranga (2018), the Government Inquiry into Mental Health and Addiction, called for a broad shift toward earlier intervention, community-based support, wellbeing, and equity. A disclosure-preparedness framework could draw on that direction, but this would be an application by the present review rather than a conclusion of the inquiry.

The Meihana Model is a Māori clinical assessment model that broadens attention to whānau, environment, social context, cultural identity, and health-system relationships. It should not be used to infer how Māori communities would respond to UAP/NHI disclosure. Any application to disclosure preparedness would require Māori-led research and governance, not extrapolation from a Western ontological-shock framework.

New Zealand has substantial earthquake, lifelines, public-health, and emergency-planning research. To support a disclosure HNA argument, the review should cite a specific health-system-load or population-preparedness study rather than relying on a general statement about Wellington fault preparedness.

On 1 July 2025, ESR became the New Zealand Institute for Public Health and Forensic Science, trading as PHF Science. It is best described as a renamed and reconstituted public research organisation rather than simply a new body replacing ESR. Its relevance to a trans-Tasman preparedness initiative is a policy recommendation, not an existing literature finding.

2.6 Australian Professional Infrastructure

Two Australian professional structures already hold a great deal of what a preparedness response would require. Neither was established with this scenario in mind, and neither needs to have been.

Psychiatry: the College has already stated the principle

The Royal Australian and New Zealand College of Psychiatrists maintains Position Statement 35, *Addressing the mental health impacts of disasters and crises*. It recommends that mental health be a key consideration in planning

and modelling responses to disasters; that care be culturally safe and trauma-informed across both immediate and long-term phases; that workforce funding and training be increased; that support for clinicians and response personnel sit inside preparedness frameworks rather than outside them; that targeted resilience and prevention resources be directed to Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, rural communities and people with pre-existing conditions; and that government support psychiatrist-led research into acute disaster mental health impacts.

The statement is explicit that psychiatrists should be engaged in prevention and resilience-building during stable periods, through training, public health leadership and research, and not only in emergency response. The College's own definition of "disasters" extends beyond natural events to acute and ongoing crises including pandemics, economic recessions and acts of terrorism, and it identifies higher-risk communities, people in rural, regional and remote areas, First Nations people, culturally and linguistically diverse communities, children and adolescents, and people with pre-existing conditions, that align closely with the vulnerable-population findings of the international disclosure-preparedness literature (section 1.2).

Read against this review, the significance is straightforward. The College has already stated the general principle. What is missing is not the position. What is missing is the evidence base that would let the position be applied to this particular class of disruption.

The most senior voice in Australian psychiatry supplies a complementary precedent. Professor Patrick McGorry AO has described clinical high-risk presentations as a "pluripotential" gateway syndrome, a phenotype warranting care while outcomes remain heterogeneous and before diagnostic categories settle; has identified removing the iatrogenic harm of the system itself as the precondition for building anything humane; and has named existential uncertainty about the future among the upstream drivers psychiatry has a responsibility to address, arguing the profession should speak to societal megatrends rather than "mopping up downstream" (Aftab, 2026). Australia has previously built nationally scaled services, early psychosis programs, headspace, for emerging, sub-threshold, heterogeneous need ahead of settled diagnostic consensus (section 2.4). That is structurally the same design problem disclosure-related distress presents. These positions concern emerging psychopathology in help-seeking young people; their extension to worldview disruption in a general population is this review's inference, offered for testing, not a claim made by their author.

The lineage behind that precedent bears directly on this review. McGorry has credited Professor Beverley Raphael AM (1934-2018) with his decision to pursue psychiatry (University of Sydney, n.d.-a; Aftab, 2026). Raphael led the psychiatric response to the January 1977 Granville rail disaster and published its psychological management in the Medical Journal of Australia within weeks of the event (Raphael, 1977, Tier 1 primary clinical account); her text on individual and community responses to catastrophe became a standard international reference (Raphael, 1986); and she went on to lead the mental health responses to the Ash Wednesday bushfires, the Newcastle earthquake and the Bali bombings, and to chair the national committee coordinating mental health responses to disasters and terrorism (University of Sydney, n.d.-b). Australian early-intervention psychiatry and Australian disaster mental health are, in this sense, connected traditions. A Health Needs Assessment on disclosure preparedness would sit at their intersection rather than outside either.

Psychology: standing capability that already spans preparation

The Australian Psychological Society has operated a Disaster Response Network since 2009: a national network of member psychologists providing individual and group wellbeing services across the preparation, response and recovery phases of disasters and collective trauma events, funded by the Australian Government and provided at no cost to eligible not-for-profit organisations.

The DRN matters here as a working example of the architecture this review argues for rather than as a proposal. It is standing capability, reached through existing channels, and its remit already includes preparation, not response alone. A preparedness assessment of the kind proposed would not be asking psychology to build something new. It would be asking what this existing network would need in order to extend to an additional class of event.

Clinical frameworks: a non-pathologising pathway already exists

DSM-5 and DSM-5-TR include "Religious or Spiritual Problem" among Other Conditions That May Be a Focus of Clinical Attention, a category expressly for distressing experiences of meaning and belief which are not, in themselves, disorders. The Cultural Formulation Interview provides a structured means of eliciting how a person's own community understands an experience before it is interpreted clinically.

Stated plainly for clinical colleagues: Australian practice already has a way to meet a person in distress about an experience that does not fit consensus reality, without either pathologising the experience or endorsing its content. What it does not have is any estimate of how many such presentations might occur, through which doors they would arrive, or what that would mean for workforce and referral pathways.

What this suggests for the assessment

Design with the bodies, not at them. The APS and the RANZCP are co-designers of the questions, not audiences for a finding. Position Statement 35 already asks for psychiatrist-led research; this is a place it could go.

Ask the workforce questions the College asks. Capacity, training, and support for the clinicians who would carry the load, PS 35 puts clinician wellbeing inside preparedness frameworks, and an assessment should test it.

Map escalation, do not invent it. From information and community support, through primary care and crisis lines, to specialist services, using the pathways that exist.

Keep the non-pathologising frame explicit. Any service-planning recommendation should be legible to a clinician as consistent with existing diagnostic practice, not as a parallel system for a special category of person.

2.7 Aboriginal and Torres Strait Islander Perspectives: Social and Emotional Wellbeing

This section is written under a deliberate constraint. Aboriginal and Torres Strait Islander perspectives on profound disruptions to shared understanding are held by traditional owners, Elders and the holders of story, and can only enter this review through their contribution and on their terms. What follows maps the existing published frameworks that any co-designed contribution could build on, acknowledges that a full and proper engagement with this literature has not yet been achieved in this version, and states plainly what this review does not do: it does not apply these frameworks to disclosure scenarios, does not speak for the communities whose frameworks they are, and does not treat their knowledge systems as data for extraction.

The social and emotional wellbeing framework

Australia holds a nationally articulated, Indigenous-authored model of wellbeing that differs at the level of ontology from the deficit-oriented clinical frameworks that dominate the international literature above. The social and emotional wellbeing (SEWB) framework, articulated by Gee, Dudgeon, Schultz, Hart and Kelly (2014) in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, describes a multidimensional model in which the self is inseparable from, and embedded within, family and community, and wellbeing arises from connection across seven interrelated domains: body; mind and emotions; family and kinship; community; culture; Country; and spirituality and ancestors. The model explicitly recognises that wellbeing is shaped by social determinants including the effects of colonisation, inequitable policy, and institutional racism.

The framework is national policy architecture, not only scholarship. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*, endorsed by the Australian Health Ministers' Advisory Council in February 2017, sets out a culturally appropriate stepped-care model built on the seven-domain SEWB model, applicable to Indigenous-specific and mainstream services alike. Subsequent and successor instruments carry the architecture forward, including the Gayaa Dhuwi (Proud Spirit) Declaration and its Implementation Framework 2025–2035, and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035, developed in partnership between Aboriginal and Torres Strait Islander peoples, government agencies and stakeholders. At state level, Victoria's *Balit Murrup* framework (2017–2027) applies the same holistic architecture.

Why this matters to ontological shock and resilience, stated carefully

The relevance is structural, and it is offered here as an observation for testing by the knowledge holders themselves, not as a finding. The SEWB framework is an existing, nationally endorsed Australian framework in which connection to Country, culture, spirituality and ancestors are constitutive of wellbeing, a framework, in other words, in which questions of meaning, reality and relationship to the more-than-human world are already held inside health, rather than referred out of it or pathologised. The international ontological-shock literature reviewed in Part One repeatedly identifies the absence of exactly this kind of holding structure as a driver of distress: assumptive worlds shattered with nothing to catch them (Janoff-Bulman), meaning-making without support (Park; Argyri et al.), clinicians defaulting to dismissal or pathologisation (Rabeyron). Whether, and how, SEWB's relational ontology bears on ontological resilience in disclosure scenarios is a question only Aboriginal and Torres Strait Islander researchers, practitioners and communities can properly frame, let alone answer.

There are also practical planning reasons this perspective is essential rather than additive: RANZCP Position Statement 35 identifies First Nations people among higher-risk groups in disasters and crises and calls for targeted resilience resourcing (section 2.6); Aboriginal Community Controlled Health Organisations are named service pathways in any realistic Australian demand model (Part Three); and the institutional-trust mechanism identified by Giddens (section 1.1) operates with particular force where institutions carry a documented history of concealment and harm.

What this version does not hold, and what would be required

A full and proper engagement with the Aboriginal and Torres Strait Islander literature, including SEWB scholarship, healing and trauma-recovery research, cultural governance of knowledge, and the substantial body of work on community-led disaster recovery, **has not yet been achieved in this version**. That is stated as a gap, not managed as a limitation.

Any future version of this section must be led or co-authored by Aboriginal and Torres Strait Islander contributors; developed under Indigenous research governance and data sovereignty principles; and structured so that traditional owners and holders of story contribute as authorities on their own knowledge, not as a population described by others. The precedent set in this review's New Zealand section applies with equal force here: the Meihana Model is noted but not applied, because application without Māori-led governance would be extrapolation. The same discipline governs this section. What this review can responsibly do, and does, is hold the space open, map the published architecture, and name the co-design requirement as a condition of the work rather than a courtesy.

Part Three: The Research Gap, Perspective Gaps, and Australian HNA Rationale

Australia has relevant infrastructure in anomalous-experience psychology, trauma and post-traumatic growth, disaster mental health, public health preparedness, community resilience, primary-care commissioning, and crisis support. What has not yet been identified in the sources reviewed is an Australian study that directly applies a health needs assessment or public-health preparedness framework to UAP/NHI disclosure.

The gap should be framed carefully. The review should not claim that no relevant Australian or New Zealand research exists unless a reproducible search method is documented. A defensible formulation is: within the databases, institutional repositories, and grey-literature sources searched for this review, no Australian study was identified that directly applied a health needs assessment or public-health preparedness framework to UAP/NHI disclosure. No equivalent New Zealand study was identified in the sources searched.

The same care applies to Basterfield's 1997 unpublished survey. The strongest claim presently available is that no recent Australian study was identified that replicates or updates the specific experiencer after-effects survey attributed to Basterfield's unpublished 1997 manuscript.

This gap is precisely what the proposed Australian Health Needs Assessment is designed to fill. The international literature has now established enough methodological precedent to justify an Australian study. That precedent includes peer-reviewed analysis of heterogeneous UAP disclosure responses, sample-level survey research on UAP witnesses, clinical frameworks for anomalous experience counselling, psychedelic integration literature as an analogue, and preprint and organisational modelling of disclosure preparedness.

Perspective Gaps Acknowledged in This Version

A literature review of this subject that presented itself as complete would be wrong twice over: wrong about the state of the literature, and wrong about who is entitled to write it. This version knows itself to be partial in at least four directions, and records them so that the co-design process (Part Four) has an honest starting point.

Aboriginal and Torres Strait Islander perspectives. Section 2.7 maps the published social and emotional wellbeing architecture, but the perspectives themselves, how profound disruptions to shared understanding are held within the oldest continuous knowledge systems on earth, belong to traditional owners, Elders and the holders of story. They can enter this review only through Indigenous-led contribution under Indigenous governance. A full engagement with the SEWB and related literature has not yet been achieved; that deep dive, and the relationships that must precede it, are named future work.

Culturally and linguistically diverse communities. CALD communities are identified as higher-risk or higher-need groups in both RANZCP Position Statement 35 and the international disclosure-preparedness literature (uNHIdden,

2026), yet this review incorporates no CALD-specific research on worldview disruption, religious and cosmological diversity in meaning-making, in-language crisis communication, or community-specific help-seeking pathways. Given that responses to paradigm-shifting information are mediated by existing worldview (Irwin, 2017; Park, 2010), the CALD dimension is not a completeness item, it is a validity item for any population-level claim.

Lived experience and experiencer perspectives. The experiencer material in this review is researcher-mediated: Mack's clinical observations, De la Torre's survey sample, the psychedelic-integration analogue. The contemporary understanding held within experiencer communities themselves, how experiencers today describe integration, what support they sought and what failed them, what they would tell a health system preparing for wider disclosure, is not yet adequately represented. Australia's own mental-health architecture supplies the corrective mechanism: the National Lived Experience Workforce Guidelines (section 2.4) already mandate lived-experience leadership in design and governance, and the experiencer-research literature reaches the same requirement independently. Experiencers are this domain's lived-experience constituency, and their contribution to this review should be governed accordingly, as expertise, not as testimony to be assessed. **Organised experiencer-support infrastructure, including MUFON's Experiencer Resource Team internationally and Australia's long-standing civilian research organisations, represents both a contribution channel for the co-design process and an under-used source of knowledge about unmet need.**

Clinical and psychosocial expansion. The clinical frameworks reviewed (Rabeyron's CIRCEE and PPAE; the DSM-5-TR non-pathologising pathway; recovery-oriented practice) establish that ontologically destabilised people can be met well. What is not yet expanded is the Australian practitioner layer: what GPs, psychologists, psychiatrists, crisis-line workers and emergency clinicians currently see, how they currently respond, and what training and guidance they would themselves ask for. Position Statement 35's call for psychiatrist-led research is the invitation; this review's professional-infrastructure section (2.6) is addressed to the bodies that could answer it.

The Assessment Architecture: National and Local

Recent Australian health-policy scholarship bears directly on how such an assessment should be structured. Duckett and London (2026), writing in the *Australian Journal of Primary Health*, examine variation across Primary Health Network needs assessments and are reported to argue that broad generalist assessments duplicate effort across thirty-one PHNs and generate expectations beyond PHNs' realistic funding remit. Their proposed remedy: define expected or average need centrally, once, and have PHNs concentrate on what is genuinely theirs, meaningful local and regional variation, and local service gaps. (The full text was not retrievable at the time of this version; the characterisation is drawn from the published citation and should be confirmed against the paper.)

Applied to disclosure preparedness, the division of labour follows naturally. System-level gaps, the absence of clinical guidance, of clinician training, of surge planning, of trusted communication protocols, are national in character and would be captured once, by the Health Needs Assessment itself. Genuine local and regional variation is the PHN layer's proper contribution: differences in community trust and help-seeking, culturally specific supports, rural and remote access, and existing local assets. That last category deserves emphasis, because local assets in this domain are easy to miss from a national vantage point. In some parts of Australia, dedicated experiencer support groups may already be operating, and already contributing to co-design processes, without any national visibility. An assessment architecture that defines expected need centrally and tasks regional structures with mapping genuine local variation, assets as well as gaps, is the architecture most likely to find them.

Australia's own civilian research organisations belong in that mapping. UFO Research Queensland, established in 1956 as the Queensland Flying Saucer Bureau, is Australia's longest-running UFO organisation; it maintains a case archive reaching back to its founding, operates public reporting channels, and publishes for a general readership. Organisations of this kind have functioned for decades as the de facto first point of contact for Australians seeking to report or make sense of an anomalous experience, which is precisely the population and the help-seeking pathway a Health Needs Assessment would need to understand. Their archives are also, on the reporting-behaviour reading applied to organisational databases in Part One, a longitudinal Australian record no health dataset replicates.

This structure is consistent with the layered population-health model running through this review (Rose; the Priestland, De la Torre and Lomas preprint), and with the commissioning machinery already in national use (section 2.4). It also answers a fair objection in advance: asking PHNs to carry a new generalist assessment burden would cut against the direction of current health-policy scholarship. This proposal asks the opposite. The national assessment does the common work once; the regional layer contributes only where regional difference is real.

Proposed Australian Health Needs Assessment Focus

HNA element	Proposed focus
Aim	Assess whether UAP/NHI disclosure scenarios could plausibly generate psychological, community, and service-support needs in Australia that exceed ordinary support capacity or require targeted preparedness.
Core population question	Which Australian population groups may be more vulnerable, more resilient, or more likely to seek support following a paradigm-shifting disclosure event?
Service-system question	What support pathways would likely absorb demand, including GPs, psychologists, psychiatrists, Lifeline and crisis lines, Medicare Mental Health Centres, PHNs, ACCHOs, schools, faith communities, and peer-support networks?
Measurement question	Which validated or adaptable measures can assess worldview disruption, ontological insecurity, distress, meaning-making, stigma, anomalous experience, social connection, and help-seeking intent?
Equity question	How should First Nations governance, culturally grounded wellbeing models, disability, youth, religion, rurality, and prior mental-health vulnerability be incorporated without imposing unsupported assumptions?
Preparedness output	A practical model for population-wide ontological resilience, targeted support for high-risk groups, clinician and crisis-line training, trusted public communication, and surge-capacity planning.

Proposed Methodological Architecture

1. Scoping review and evidence map: classify peer-reviewed, preprint, conference, government, organisational, lived-experience, and unpublished evidence separately.
2. Stakeholder mapping: identify health, mental-health, crisis-support, community, faith, First Nations, experiencer, youth, disability, scientific, education, and communication stakeholders.
3. Population survey: measure awareness, anticipated response, worldview disruption, stigma, help-seeking intent, trust in institutions, community connection, and support preferences.
4. Qualitative interviews or focus groups: include experiencers, clinicians, faith leaders, young people, First Nations governance representatives, crisis workers, sceptics, and science communicators.
5. Scenario modelling: test several disclosure scenarios without making claims about what is true or imminent, and model likely support pathways under low, moderate, and high-distress assumptions.
6. Clinical translation: develop training guidance for clinicians and crisis workers that avoids both dismissal and uncritical confirmation.
7. Governance translation: produce practical recommendations for PHNs, Medicare Mental Health Centres, crisis lines, state health systems, professional bodies, and community organisations.

Defensible Campaign Claim

Recommended formulation
An emerging international literature identifies plausible psychological and public-health preparedness issues associated with paradigm-shifting disclosure scenarios. Australia has relevant expertise and health-system infrastructure, but no Australian Health Needs Assessment was identified in the sources reviewed. A carefully designed HNA would convert the current evidence-informed concern into testable Australian data and practical service planning.

Part Four: Co-Design and Contribution Process for a Living Document

This review is offered as an emerging piece of academic infrastructure: a versioned, tiered, openly gap-declaring evidence base intended to underpin the design of an Australian Health Needs Assessment, and intended to be built with the professions, communities and knowledge holders it concerns rather than presented to them.

What this document is not. It is not final. It has not been through any broader consultation process. It is not a systematic review, and it does not claim completeness in any direction. No version of it should be cited as the settled state of the field.

What it is for. It is a starting resource: what the literature currently says, how it is categorised by evidence tier, and which perspectives are not yet adequately represented, assembled so that consideration of how to proceed can begin from an honest map rather than from assertion.

How contributions enter. Contributions are incorporated in versioned amendments with a change log, so that the document's own history remains auditable. Sources enter at a labelled evidence tier, whatever their register: peer-reviewed work, professional-body positions, community-authored frameworks, and lived-experience contributions are each cited as what they are. Disagreement is recorded rather than resolved by omission, where contributors dispute a framing, the dispute itself is documented.

Who the co-designers are. The professional bodies whose infrastructure would carry any response (the RANZCP and APS foremost, per section 2.6); the research communities already working on anomalous experience, trauma and disaster recovery (sections 2.1–2.2); Aboriginal and Torres Strait Islander traditional owners and knowledge holders, under Indigenous governance, as authorities on their own knowledge (section 2.7); culturally and linguistically diverse communities; experiencers and the lived-experience workforce; and the service systems, PHNs, ACCHOs, crisis lines, Medicare Mental Health Centres, whose planning questions the Health Needs Assessment would answer.

The standard the document holds itself to. The same one it asks of its readers: evidence labelled honestly, absence claims made only relative to a recorded search, first-person authority respected, and every version prepared to be corrected by the next.

Appendix A: Search and Verification Method

This review makes negative claims, studies not identified in Australia and New Zealand, and an absence claim is only as good as the search behind it. This appendix records the searches conducted to date. It will be extended as further databases are searched, and any reader able to falsify the central absence claim is asked to do so.

- Date of search and reviewer. Verification searches executed on 20 August 2026 (AEST) by the author with AI research assistance, results reviewed by the author. Earlier unlogged searching (July and August 2026) informed the body of the review; the 20 August searches re-tested its central absence claim.
- Databases searched on 20 August 2026: PubMed (US National Library of Medicine) and the general web index. Not yet searched: PsycINFO, Scopus and Web of Science (subscription access unavailable at the date of search); Trove (automated access unavailable, manual search recommended); Google Scholar (not systematically searched); university repositories and government grey-literature repositories. The finding below is provisional relative to these.
- Search 1. PubMed, exact phrase "unidentified anomalous phenomena": 2 results, both 2025 observational-astronomy and instrumentation papers (Palomar Observatory Sky Survey transients; an all-sky infrared camera array). Neither is a health study.
- Search 2. PubMed, exact phrase "ontological shock": 6 results, all within the psychedelic and anomalous-experience literature this review already covers (including Argyri et al., 2025, and Rabeyron, 2022). No Australian population study. One 2026 paper on managing distress from ontologically challenging psychedelic experiences was identified in this search and is held for assessment in the next version.
- Search 3. PubMed, (UAP OR UFO OR "non-human intelligence") AND "health needs assessment": 0 results.

- Search 4. PubMed, "anomalous experience" AND Australia: 4 results (2001 to 2020), none a needs assessment or preparedness study.
- Search 5. General web index, "health needs assessment" combined with unidentified anomalous phenomena, disclosure preparedness and Australia: returned international preparedness material (Disclosure Foundation; Sol Foundation white papers) and Australian parliamentary and advocacy items. No Australian Health Needs Assessment was identified.
- Limits: English language, no date limit, all publication types.
- Citation chaining: conducted from the core papers (Argyri et al., 2025; Evans et al., 2023; De la Torre, 2024; Lomas, 2025) during compilation of Parts One and Two.
- Handling rules: preprints are identified as preprints; conference presentations as forthcoming; organisational survey data at the tier of its publisher; unpublished and archival material is named as such, including the Basterfield 1997 manuscript.
- Finding at 20 August 2026: no Australian Health Needs Assessment addressing UAP or NHI disclosure scenarios was identified in any search above. If such an assessment exists, the most useful outcome of circulating this review remains that somebody says so.

References

Aftab, A. (2026, 13 February). Clinical staging, early intervention, and youth mental health: An interview with Patrick McGorry. *Psychiatry at the Margins*.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Association.

Argyri, E. K., Evans, J., Luke, D., Michael, P., Michelle, K., Rohani-Shukla, C., Suseelan, S., Prideaux, E., McAlpine, R., Murphy-Beiner, A., & Robinson, O. C. (2025). Navigating groundlessness: An interview study on dealing with ontological shock and existential distress following psychedelic experiences. PLoS ONE, 20(5), e0322501. https://doi.org/10.1371/journal.pone.0322501

Australian Psychological Society. (n.d.). *Disaster Response Network* (established 2009). psychology.org.au.

Bartholomew, R. E., Basterfield, K., & Howard, G. S. (1991). UFO abductees and contactees: Psychopathology or fantasy proneness? Professional Psychology: Research and Practice, 22(3), 215-222.

Basterfield, K. (1997). An analysis of an Australian survey questionnaire on the after-effects of UFO abductions [Unpublished manuscript, location to be specified if cited].

Byrne, L., et al. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

Byrne, L., Stratford, A., and Davidson, L. (2018). The global need for lived experience leadership. Psychiatric Rehabilitation Journal, 41(1), 76-79.

Commonwealth of Australia. (2013). A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Department of Health and Ageing.

Commonwealth of Australia. (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*. Endorsed by the Australian Health Ministers' Advisory Council, February 2017.

Corio, E., & Pérez Simondini, A. (2026, 31 July). X International UFO Congress in Argentina and the evolution of Latin American UAP research. *The SCU Review*, 7(3), Publication No. 26. Scientific Coalition for UAP Studies.

De la Torre, G. G. (2024). Psychological aspects in unidentified anomalous phenomena (UAP) witnesses. International Journal of Astrobiology, 23, e4. https://doi.org/10.1017/S1473550423000289

Disclosure Foundation. (2026). The psychological impact of UAP/NHI disclosure. Disclosure Foundation.

Duckett, S., & London, J. (2026). The false promise of Primary Health Network generalist needs assessments. *Australian Journal of Primary Health*. https://doi.org/10.1071/PY26139 (Full text not retrieved at this version; characterisation from the published citation, to be confirmed against the paper.)

Evans, J., Robinson, O. C., Argyri, E. K., Suseelan, S., Murphy-Beiner, A., McAlpine, R., Prideaux, E., & Luke, D. (2023). Extended difficulties following the use of psychedelic drugs: A mixed methods study. PLoS ONE, 18(10), e0293349. https://doi.org/10.1371/journal.pone.0293349

Gayaa Dhuwi (Proud Spirit) Australia. (2025). *Gayaa Dhuwi (Proud Spirit) Declaration Implementation Framework 2025–2035*.

Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Aboriginal and Torres Strait Islander social and emotional wellbeing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 55–68). Commonwealth of Australia.

Giddens, A. (1990). The consequences of modernity. Polity Press.

Giddens, A. (1991). Modernity and self-identity: Self and society in the late modern age. Polity Press.

Gow, K. M., Lurie, J., Coppin, S., Popper, A., Powell, A., & Basterfield, K. (2001). Fantasy proneness and other psychological correlates of UFO experience. European Journal of UFO and Abduction Studies, 2(2), 45-66.

Greenberg, J., Pyszczynski, T., & Solomon, S. (1986). The causes and consequences of a need for self-esteem: A terror management theory. In R. F. Baumeister (Ed.), Public self and private self (pp. 189-212). Springer.

Harms, L., Molyneaux, R., Nguyen, H., Pope, D., Block, K., Gallagher, H. C., Kavanagh, S. A., Quinn, P., O'Donnell, M., & Gibbs, L. (2024). Individual and community experiences of posttraumatic growth after disaster: 10 years after the Australian Black Saturday bushfires. Psychological Trauma: Theory, Research, Practice, and Policy, 16(2), 303-311. https://doi.org/10.1037/tra0001500

Inter-Agency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. Inter-Agency Standing Committee.

Irwin, H. J. (2015). Paranormal attributions for anomalous pictures: A validation of the Survey of Anomalous Experiences. Journal of the Society for Psychical Research, 79(1), 11-17.

Irwin, H. J. (2017). An assessment of the worldview theory of belief in the paranormal. Australian Journal of Parapsychology, 17, 7-21.

Irwin, H. J. (2018). Stress sensitivity and minimal-self dysfunction as predictors of anomalous experiences and paranormal attributions. Journal of the Society for Psychical Research, 82(1), 1-14.

Janoff-Bulman, R. (1992). Shattered assumptions: Towards a new psychology of trauma. Free Press.

Laing, R. D. (1960). The divided self: An existential study in sanity and madness. Tavistock Publications.

Lomas, T. (2025). Unidentified anomalous phenomena (UAP) disclosure as ontological shock? Exploring diversity among social media responses to a Congressional UAP hearing. Journal of Humanistic Psychology, 65(3), 654-688. https://doi.org/10.1177/00221678241251871

Mack, J. E. (1994). Abduction: Human encounters with aliens. Scribner.

Marden, K., and Stoner, D. (2012). The Marden-Stoner study on commonalities among UFO abduction experiencers: Final report. https://www.kathleen-marden.com/the-marden-stoner-commonalities-study.php

McGorry, P. D., Hickie, I. B., Yung, A. R., Pantelis, C., and Jackson, H. J. (2006). Clinical staging of psychiatric disorders: A heuristic framework for choosing earlier, safer and more effective interventions. Australian and New Zealand Journal of Psychiatry, 40(8), 616-622.

McGorry, P. D., Mei, C., Dalal, N., et al. (2024). The Lancet Psychiatry Commission on youth mental health. The Lancet Psychiatry, 11(9), 731-774. https://doi.org/10.1016/S2215-0366(24)00163-9

Mental Health Lived Experience Engagement Network and National Mental Health Consumer and Carer Forum. (n.d.). Lived Experience Digital Library: Lived experience leadership collection. https://livedexperiencedigitallibrary.org.au/browse-library/lived-experience-leadership

Mutual UFO Network. (n.d.). Experiencer Resource Team. https://mufon.com/experiencer-resource-team-ert/

Mutual UFO Network. (n.d.). Research and the case management system. https://mufon.com/research/

New Zealand Government. (2018). He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. Psychological Bulletin, 136(2), 257-301. https://doi.org/10.1037/a0018301

Powell, R. (2026, 31 July). Support of academia. *The SCU Review*, 7(3), Publication No. 26. Scientific Coalition for UAP Studies.

Priestland, J., De la Torre, G. G., & Lomas, T. (2026). Ontological resilience in paradigm-shifting disclosure: A health needs assessment. Preprints.org. https://doi.org/10.20944/preprints202605.1417.v1

Rabeyron, T. (2022). When the truth is out there: Counseling people who report anomalous experiences. Frontiers in Psychology, 12, 693707. https://doi.org/10.3389/fpsyg.2021.693707

Raphael, B. (1977). The Granville train disaster: Psychological needs and their management. Medical Journal of Australia, 1(9), 303-305.

Raphael, B. (1986). When disaster strikes: How individuals and communities cope with catastrophe. Basic Books.

Rose, G. (1992). The strategy of preventive medicine. Oxford University Press.

Royal Australian and New Zealand College of Psychiatrists. (2025/2026). *Position Statement 35: Addressing the mental health impacts of disasters and crises*. ranzcp.org.

Siskind, D., Harris, M., Buckingham, B., Pirkis, J., and Whiteford, H. (2012). Planning estimates for the mental health community support sector. Australian and New Zealand Journal of Psychiatry, 46(9), 867-880. https://doi.org/10.1177/0004867412443058

State of Victoria, Department of Health and Human Services. (2017). *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017–2027*.

The uNHIdden Foundation. (2024). The impact of exceptional experiences and disclosure on mental health and wellbeing. The uNHIdden Foundation.

The uNHIdden Foundation. (2026). Preparing for disclosure: A public health framework for paradigm-shifting revelations. The uNHIdden Foundation.

Tillich, P. (1952). The courage to be. Yale University Press.

UFO Research Queensland. (n.d.). About UFORQ; A brief history of UFO Research Queensland. https://uforq.org/

University of Sydney, Faculty of Medicine Online Museum and Archive. (n.d.-a). McGorry, Patrick. sydney.edu.au.

University of Sydney, Faculty of Medicine Online Museum and Archive. (n.d.-b). Raphael, Beverley. sydney.edu.au.

Wendt, A. (2026, forthcoming October). *The last humans: UFOs, global security, and the threat to state sovereignty*.

Whiteford, H. A., Degenhardt, L., Rehm, J., et al. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. The Lancet, 382(9904), 1575-1586. https://doi.org/10.1016/S0140-6736(13)61611-6