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The Israel-Hamas War – Guiding Principles and Standards for Interventions Following a Mass Casualty Disaster, Loss, and Bereavement: A Review of the Literature

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Main Points

- Ever since the outbreak of the Israel-Hamas war on October 7, 2023, the number of people in need of emotional support to cope with loss, bereavement and trauma has grown exponentially. The ongoing emergency – due to both the continued hostilities and the inability of evacuees to return home because of the continued security situation in their communities of origin – has deepened the trauma, stress reactions, and distress among large sections of the Israeli population. The present study is published some three months after the outbreak of the war to help policymakers and professionals develop the medium and long-term interventions, for families and communities dealing with trauma, loss, and bereavement, that are necessary at this stage of the response to the disaster. However, to facilitate advance preparation for situations arising immediately after a disaster of this kind, the document also addresses short-term responses and interventions.
- The literature on the preparation of countries for disasters and their responses to them indicates that the first response stage is characterized by chaos and confusion, hence the importance of advance preparation. Several principles guide countries' responses to disasters. All share the need to protect the population's physical health and socioemotional wellbeing, the need to assist as many people as possible as quickly as possible, and the need to ensure an effective intervention that will prevent the development of mental disorders in the long run. These principles include: (1) advance preparation by the health system; (2) immediate response and mental health first aid; (3) a proactive approach by professionals in order to offer psychosocial assessment and follow-up to a wide circle of affected individuals; (4) coordination between a wide range of agencies, services, and officials; (5) training professionals in crisis-specific competencies; (6) relying on nonprofessional staff and members of the community to provide preliminary support; (7) identifying the affected individuals' needs in the immediate and long terms, and monitoring their ongoing needs by mental health professionals and professionals in the health, welfare, education and other community service areas; (8) planning interventions directed to large numbers of individuals directly or indirectly affected by the disaster; (9) dedicating resources and adjusting interventions to the needs of vulnerable populations; and (10) national planning of policies and activities and allocating budgets and resources to local authorities, so that these policies can be implemented on the local level.

- The response to the disaster may be likened to a pyramid. Its broad base represents basic services and security for the general population, whereas its tip represents expert interventions focused on a small number of affected individuals. Moreover, the types of intervention must be adjusted to the specific situation and the stage of coping with the disaster. Immediate intervention (from the moment the disaster strikes to a week afterward) is provided to those directly affected by a traumatic event, whereas mid-term intervention (from one week to two months after the event) and long-term intervention (two months and more after the event), which may overlap, are designed for people who experience psychological reactions or develop long-term symptoms. There is a rich variety of interventions for coping with various levels of psychological reactions – from individual psychotherapy, support-group or individual cognitive-behavioral therapy (CBT) to less traditional approaches such as art and animal-assisted therapy, that serve as alternatives to traditional talk therapy.
- Immediately following the disaster, and for as long as possible, attention must be given to the general public. The emotional response of those exposed indirectly to a terror attack can be made worse by sensationalization in the media or poor communication of guidelines by public officials. Preventive actions must be directed at enhancing the public's sense of resilience and self-efficacy. One of the most important resources for coping with the effects of disasters that government and other organizations can provide to the public is information – general information on the scope and nature of the disaster and, more specifically, information about ways of reducing distress and building resilience. It is also important to provide families with reliable information about their loved ones.
- Community-based support systems represent another important way of strengthening community resilience and enhancing recovery and rehabilitation efforts: mental health professionals and organizations that focus on building resilience can contact community leaders and work with them to provide aid; local religious leaders can provide spiritual support; and community intervention models that take the community's strengths into account, and enable it to gradually resume control over the lives and agendas of its members may be implemented.
- In the area of loss and bereavement, the literature indicates that not all individuals require the same level of help and support. Most bereaved people will benefit from encouragement, recognition of their loss, and access to information about working through their loss and sources of help and support. A few will require professional intervention. To make the most of available resources and provide customized services to all those in need, the support provided must be informed by individual diagnosis and assessment. It is also important to provide information about sources of support and available services that are offered by non-therapeutic professionals, such as the educational staff in schools, to broaden the circle of support.

- Organizations offering bereavement support services or counseling must adopt standards of practice that will ensure that the service they offer meets the needs in the field. They must ensure the quality of the staff; provide training and support for volunteers; maintain an ethical code of conduct; adjust the service and intervention to the personal characteristics and needs of the bereaved – such as their religion, culture, gender and age; be available to all bereaved individuals within a reasonable time and at various stages of their grief; and establish a continuum of prevention and therapeutic services.
- The basic premise of interventions for coping with loss and bereavement is that grief and adjustment to loss are natural responses, and that every person is potentially capable of adjusting to loss, given the appropriate care and support. Accordingly, we can learn from the rich literature about the wide range of interventions in this area, and about the diverse approaches for coping with these situations - from educating for grief and providing coping strategies, through group support and sharing, to spiritual care. The most common theoretical frameworks in models and programs are developmental theory, CBT, trauma-oriented therapy, and expressive and meaning therapy. Moreover, one of the major approaches in treating bereaved individuals is support for the family process of coping with grief, based on the idea that the family is the main source of support in times of crisis and loss.
- Based on the review of the literature, several recommendations are offered for coping with Israel's current situation, and with future crises:
    - Develop a systemic view of coping with trauma, loss, and bereavement
    - Direct national resources to the local authorities
    - Take a proactive approach to identifying needs
    - Provide interventions for all coping stages and according to the levels of intervention necessary
    - Channel resources to high-risk populations and customize the interventions provided to them
    - Train and support professionals in the areas of trauma, loss, and bereavement
    - Expand the range of professionals providing aid and support
    - Implement community intervention models
    - Provide group intervention and complementary support tools
    - Provide meeting spaces for support and information sharing
    - Use the media to disseminate reliable and resilience-building information
    - Heighten awareness of the subject of loss and bereavement

1. Introduction

1.1 Background

Ever since the outbreak of the Israel-Hamas war in October 2023, the number of individuals in need of emotional support to cope with loss, bereavement and trauma has increased significantly. In addition, many others are coping with uncertainty and helplessness due to the lack of information about their loved ones. The ongoing state of emergency – due to both the continued hostilities and the inability of evacuees to return home because of the continued security situation in their home communities – has deepened the trauma, stress reactions and distress among large sections of the Israeli public.

In a previous document (Ben Simon et al., 2023), we presented insights from the literature on the impact of disasters on communities as well as on the effects of loss and bereavement on individuals and families. This document showed that several factors can create wide circles of people who are affected by the current traumatic events in Israel: (1) the collective trauma that characterizes life in Israel during the Israel-Hamas war; (2) multiple potential triggers which may cause prolonged grief disorder; (3) life in the shadow of a continued threat; (4) a high degree of uncertainty; and (5) the large number of evacuees. The review of the literature also suggested the need for the State to provide treatment to the affected populations and develop interventions that will help them resume their normal routine. These services must be based on early diagnosis of people experiencing severe reactions that require special interventions, as well as on attention to populations at risk and customizing the interventions to individual needs. This document addresses a required emergency plan and the necessary interventions. It is written some three months after the outbreak of the war, and therefore also reviews recommended intervention approaches for the mid- and long-term stages of the response to the disaster. It also presents recommended immediate interventions, to help in similar situations in the future. The document starts by reviewing the action principles in response to a mass-casualty disaster and reviewing recommended interventions for coping with trauma and distress in the immediate, middle and long term. This is followed by the standards of practice for interventions around loss and bereavement, and best practices for treating and supporting family members coping with loss and bereavement. Finally, we offer practical recommendations for coping with the effects of the war on the general Israeli population.

1.2 Objectives of the Review

This review is designed to help policymakers and professionals plan short- and long-term interventions for individuals, families and communities coping with trauma, loss, and bereavement. The goal of the review is to identify recommended standards of practice following a mass-casualty disaster, as well as best practices for intervention in the area of loss and bereavement.

Accordingly, the document addresses the following issues:

- **Countries' strategies for coping with crises and disasters**: Standards and guiding principles adopted by government agencies and other organizations in coping with mass-casualty disasters, and the types of interventions proposed, with particular attention to the heterogeneity of needs and to the stages of coping with the disaster
- **Standards of practice and types of intervention for loss and bereavement**: Standards for operating services for the bereaved, common therapeutic approaches, and the adaptation of interventions to the characteristics of populations at risk

1.3 Method

The review is based on academic publications on how countries and local authorities cope with disasters, as well as on systematic reviews analyzing studies on responses to and interventions following disasters. The articles reviewed dealt with both natural and human-made disasters, but our focus was on articles dealing with responses to terror attacks. We also reviewed academic articles and grey literature (policy papers, evaluation studies, organizational websites, etc.) on intervention approaches and programs on loss and bereavement. Please note that the third section, dealing specifically with loss and bereavement, is based on the literature review which was part of an evaluation study of policy for treating families with children who have experienced civilian loss and bereavement (Toporek Barr et al., 2023).

2. Coping with Crises and Disasters Worldwide

In the wake of mass-casualty disasters, countries worldwide implement policies designed to meet the needs of the individuals directly affected and of the general population. Together with initiatives developed prior to the disaster, these countries usually develop new approaches and institute reforms in existing systems in order to optimize the services provided (Nilsen & Stene, 2023). This section reviews the literature on countries' preparations for disasters, with an emphasis on terror attacks, and the way they cope with the impact of these disasters. First, we present guidelines for dealing with mass-casualty disasters, followed by a description of the stages and levels of various types of intervention.

2.1 Guidelines for Dealing with Mass-Casualty Disasters

The primary task following a disaster is to protect the population's physical and socioemotional wellbeing. The responses to such emergencies are often complex, including different stages, multiple types of interventions, and many players (Nilsen & Stene, 2023). The literature reports several principles that guide the planning of programs for preparing for disasters and responding to their impact:

- **Advance preparations by the healthcare system** – The healthcare system plays a decisive role in protecting the health and wellbeing of the population. Preparedness of the public health system for emergencies is designed to enable it, together with the other healthcare systems, communities, and individuals, to protect against disasters, respond quickly when they occur, and recover from them, particularly in crises whose scope, timing, or unpredictability threaten the ability to respond as in routine situations (Nilsen & Stene, 2023).
- **Immediate response** – The speed of the response after a terror attack can have a decisive impact on the physical and emotional wellbeing of the affected populations. This response includes preliminary actions to save people, identify casualties and others affected, register them, reunite relatives, and provide both physical and mental health first aid. Mental health first aid includes short-term intervention programs designed to alleviate stages of extreme stress and prevent the development of post-traumatic symptoms (see more below). Adequate management of the first response stage can play a key role in reducing its impact on people not directly exposed to the disaster, such as relatives and friends of the directly affected individuals, members of their community and of the community under attack, witnesses, first responders and other professionals (Askenazy et al., 2022).

- **Proactive approach** – Given the potential for mass casualties in terror attacks, the approach to providing mental health first aid must be proactive (Nilsen & Stene, 2023). According to Harrop et al. (2020), this is a key element of post-disaster interventions. Thus, emergency staff should also include mental health experts who can provide emergency care and support (Nilsen & Stene, 2023), and these professionals are expected to reach out to all directly affected individuals and offer psychosocial assessment and follow-up (Kärki, 2015).
- **Coordinating the work of a variety of organizations and services** – A terror attack and the trauma that follows challenge the service system's ability to provide services to the affected population. Not only must it provide services for a large number of individuals and train special teams for that purpose, but the activities must be synchronized over time, maintaining effective and continuous cooperation between a variety of services operating on different levels in hundreds of local authorities (Kärki, 2015). The immediate post-disaster stage is characterized by the involvement of professionals from a variety of fields: first responders, such as law enforcement officers, paramedics, emergency medical technicians, firefighters, police, NGO volunteers, as well as different categories of clinicians, such as physicians, psychiatrists, psychologists, and nurses. These professionals must operate under chaotic and uncertain conditions and must constantly coordinate their activities with other professionals (Askenazy et al., 2022). Given the conditions prevailing at this stage, it is recommended that law enforcement officers should be sent to manage and coordinate activities in the field, as well as to enforce law and order (Foa et al., 2005). In the first post-disaster stage, it is essential for officials to work closely with mental health experts and the health services in general, given the urgent responsibilities of these services at this time (Foa et al., 2005; Kärki, 2015). Coordination must continue after the acute stage, in order to organize the provision of services for the population.
- **Training the professional staff** – In disasters, it is important to provide training in crisis-specific competencies for professionals (Harrop et al., 2020), since their preparedness to deal with mass trauma is a key element in ensuring effective interventions (Askenazy et al., 2022; Nilsen & Stene, 2023). Training must include at least the following topics: initial triage, registration, screening, initial support, referral of the affected individual to the appropriate practitioner and services, and attending to populations at high risk. Such training must also include models for identifying risk factors for the development of PTSD and other mental disorders, including among the professional members of the emergency teams themselves, as well as explaining how to identify potential symptoms and provide self-care. Inter-professional and international remote training sessions can be useful for sharing knowledge among professionals regarding their roles and responsibilities, thereby improving the coordination of responses and providing guidance on best practices based on the experience of professionals from other countries. Another advantage of remote training is the ability to train multiple

professionals who are not located in the same place. Nevertheless, online sessions cannot replace face-to-face training, as they do not enable simulating real-life events, role-play, and group exercises – all essential for training professionals. A combination of remote theoretical learning and face-to-face training that includes hands-on experience in emotion regulation, decision making under pressure, and interpersonal collaboration, is recommended (Askenazy et al., 2022).

- **Relying on nonprofessional members of the community for first response** – Given the need to provide initial treatment quickly to a very large number of individuals, it is impossible to rely exclusively on skilled professionals. As much as possible, trained professionals should instruct and supervise less skilled professionals as well as volunteers with relevant backgrounds such as teachers, HR professionals and religious leaders. It should be noted that, in the wake of a disaster, family members and neighbors do as much as they can to help the affected individuals, and therefore, they should be considered a precious resource. First responders must identify those willing and able to help, and make use of them (Foa et al., 2005).
- **Identifying needs** – An effective response to a disaster must be informed by an understanding of the affected individuals' needs in the immediate and long term. Needs identification is the responsibility of mental health experts and stakeholders from a variety of areas: representatives of the health, welfare, and education systems, local authority representatives, professionals, and representatives of relevant NGOs - and these experts and stakeholders must also monitor evolving needs. This process must include representatives of the bereaved, and of the survivors and their families to enable optimal assessment of needs and monitoring the needs over time (Kärki, 2015). Since it is important to identify individuals with acute reactions to the event early on, schools, workplaces and the public must be made aware of signs of acute distress and should know how to refer people to the services required. To be able to identify those in need of greater support, the affected individuals must remain in contact with others, and not be isolated. Therefore, it is recommended to establish centers where people can meet and seek counseling and guidance, staffed by a mental health professional along with professionals with lower levels of training and volunteers (Foa et al., 2005).
- **Planning mass-casualty interventions** – In mass-casualty disasters, we refer to three circles of affected individuals. The first includes the survivors, those directly affected by the disaster, and local first responders. The second includes family members and friends of the deceased, the survivors and bereaved, first responders and witnesses. The third circle includes those experiencing stress responses due to their geographical or emotional proximity to the disaster and others showing signs of acute distress (Foa et al., 2005; Kärki, 2015; Lee et al., 2016). Studies show that second- and third circles of affected individuals are expected to experience mental issues due to the community nature of the disaster, to the point of developing PTSD

(McLennan et al., 2016). Therefore, when developing interventions, it is important to assess the impact of the disaster on the mental health of the direct victims, as well as on all those exposed to it or living nearby, and to attend to the three circles of affected individuals in order to minimize the risk for the development of complex PTSD symptoms (Lee et al., 2020). A terror attack can also affect tourists or other foreigners who do not speak the local language and cannot benefit from family or social support, medical insurance, or the legal system (for compensation), as can local citizens (Askenazy et al., 2022).

- **Dedicated resources and services for high-risk populations** – An extreme reaction to a terror attack and the evacuation of inhabitants from the disaster area may characterize minority groups and individuals with low levels of education. Additional populations at high risk are Holocaust and war survivors, new immigrants, women, evacuees, people with a history of mental disorders and mental patients (Foa et al., 2005). Children are also considered a risk group, and particular attention is devoted to them in disaster preparation plans (Nilsen & Stene, 2023). A study conducted several years ago in Israel among older adults aged 65+ in communities bordering on the Gaza Strip examined how they were coping with the ongoing security threat and demonstrated the need to provide interventions adjusted to the needs of this unique group as well. The findings showed that coping patterns were related to the individual's stage of life (in this case older age), the nature of their community, and to differences in intergenerational patterns. They also showed that the older adults were preoccupied with issues particular to that group during periods of continuous threat, and that the intervention had to be customized to those needs (Nuttman-Shwartz & Regev, 2018).
- **Global thinking, local action** – One of the arguments made in the professional literature is that there are several reasons that governmental agencies find it difficult to provide effective support in the wake of a disaster. These include excessive supervision and many officials authorized to veto decision making or resource provision. An article on disaster relief activities in the wake of Hurricane Katrina argued that the response of the private sector was rapid and effective, whereas the government's response was confused, chaotic and slow. According to the authors, private companies were willing and able to use their resources in the disaster areas days before the government was able to do so. They recommended depoliticizing the post-disaster response and delegating greater responsibilities to private companies in managing the response (Sobel & Leeson, 2006). Conversely, other articles recommend national policymaking and planning, and that resources for implementing the response plan be directed to the local authorities for local implementation according to the needs in the field (Haffajee & Mello, 2020; Harrop et al., 2020). An Israeli study that examined rehabilitation programs for the communities of Jewish settlers evacuated from the Gaza Strip in 2005 found a significant gap between the government's stated intention to support community rehabilitation and its

actual capacities. The reasons included the government's difficulty in implementing activities that diverged from its routine practices; its choice to provide compensation rather than rehabilitation; and its difficulty in identifying communities and recognizing them as entities entitled for support, and in adjusting its activities to the needs of each community and its changing needs over time (Ben Yosef, 2009).

- **Allocating and directing budgets** – In times of national crisis, the government allocates budgets to help affected citizens and to implement interventions for them. These funds are allocated to provide financial support to individuals and businesses, healthcare, and other systems, as well as to increase the budgets of central and local authorities that provide necessary services (GAO, 2021). It is crucial to respond quickly to the disaster, but also to ensure appropriate use of the funds based on predetermined rules, and channel them to those most in need.

2.2 Types of Responses to Disasters

Support in the wake of a disaster must take into account the heterogeneous needs of the affected population and the necessity for different kinds of support. If we liken the disaster response to a pyramid, its broad base represents basic services and safety for the general population, whereas its tip represents expert interventions focused on a small number of individuals (Nielsen & Stene, 2023). Moreover, the types of interventions must be adjusted to the specific situation and the stage of coping with the disaster and can therefore overlap even if they are represented as distinct types of interventions. The first, acute stage of response can last between one week and one month, according to the characteristics of the event (Askenazy et al., 2022), and the duration of the various types of interventions is determined by the type of psychological reactions and the target population. For example, the definition of immediate intervention is from the moment of the disaster until one week later. It is designed for those directly affected by an extreme, traumatic event. Medium-term intervention is usually provided from one week to two months after the disaster, whereas long-term intervention is designed for individuals experiencing distress two months and more after the disaster (Dyregrov et al., 2019). The following are common types of intervention provided to the general population and to individuals, respectively.

Interventions for the General Population

Beyond rescue and aid efforts in the disaster area in the immediate post-disaster stage, attention is directed to the general population. The emotional response of those not affected directly by a terror attack is expected to be minor to moderate, but it might be exacerbated following sensational reporting of the event by the media, or poor communication of official instructions. Preventive actions must be directed at increasing the public's sense

of resilience and self-efficacy. Therefore, official communiques must (1) be clear; (2) describe the situation on the ground and its effects; (3) reduce fear of unlikely threats; and (4) report what is being done (Foa et al., 2005). In a wartime situation such as that currently experienced by Israel, this stage can continue for a long period of time, ie., as long as the threat exists.

- **Information** is one of the key coping resources that government authorities and other organizations can provide to the public. Information reduces uncertainty and helps individuals adjust to the situation and cope with the stress experienced due to the disaster (Liu & Ni, 2021). In the specific case of a terror attack, government authorities and other organizations must identify the type of threat faced by the population, provide general information about the type and scope of the threat, and communicate reliable information about the disaster, so that the population remains vigilant, while at the same time being able to resume their normal routine. To help the public and emergency workers build up emotional resilience and reduce their stress, it is suggested that the national media, especially the electronic media such as TV, radio and internet, communicate the interventions, which can include instruction in relaxation, meditation, and guided imagery; recommend activities that can help recover a sense of control; advise on limiting exposure to the recurring reports on the disaster in the media and limiting children's exposure to the media; and broadcast community meetings where people can consult with a panel of mental health experts (Foa et al., 2005). Studies show that information provided by the government and civil society organizations through the media is essential for developing community resilience, since it supports the community's ability to recover from the disaster by reporting on available resources and thus increasing the utilization of services that can help cope with the disaster (Liu & Ni, 2021). Accordingly, in planning healthcare and social services, policymakers and service providers should include publicizing these services, to enable optimal access to them (Harrop et al., 2020).
- **Establishing communication centers and hotlines and using local media and the internet for community needs** (Foa et al., 2005) – One of the ways to deliver information to family members of individuals affected by disasters is to establish on-line communication and service centers where relatives can leave messages to family members. These centers can provide reliable information about casualties and survivors as well as providing a sense of community to those affected by the disaster, mutual support and sharing. In the information center, it is also possible to provide access to psychosocial interventions. For the information center to operate effectively, interorganizational collaboration is necessary (van Herpen et al., 2022).
- **Enhancing national resilience** – National resilience is the ability of individuals in a society that has experienced disaster or is engaged in an ongoing conflict to maintain the stability of their fundamental views and beliefs

that weave their collective social fabric (Ben-Dor et al., 2008). Resilience also refers to the individuals' ability to harness the resources that will maintain their wellbeing. This ability can persist as long as their ecological-social environment, including family, community, and government, assures that these resources remain available (Osofsky & Osofsky, 2018). Unlike individual resilience, national resilience is structured by factors such as socioeconomic strengths and trust in the political leadership, which in turn affect the public's emotions and daily behavior (Tuval-Mashiach, 2008). Therefore, one of the ways to enhance resilience in the wake of disasters is to strengthen social infrastructures in the community – to build social capital (Osofsky & Osofsky, 2018).

- **Providing community-based support systems** – Accordingly, it is suggested that individuals and organizations be provided with ways to help the community by themselves. For example, in many communities spiritual support may be provided by local religious leaders, and it is therefore recommended that mental health professionals contact community-based support systems that can help them help others (Foa et al., 2005). Models of community intervention may also be implemented, such as the model used in the Nahal Oz community, bordering on the Gaza Strip, during the 2014 war in Gaza to help the inhabitants cope with the traumatic events and continuous security threat. The model's guiding principles included creating a community space to work through the grief and address the loss; creating a renewed narrative for the individual and community identity following a traumatic event; repositioning the core leadership of the community and establishing an agenda and priorities for organizing aid activities; reaching out by helping professionals to give the community members the feeling that help and support are available; adjusting the intervention methods to the community's strengths to ensure meaningful social and community activities; and multistage interventions in order to gradually hand leadership and control back to the members of the community, according to the community's progress in recovery and healing (Sarid, 2017).

Interventions for Directly Affected Individuals (Mental Health First Aid)

In the first post-disaster period, strong emphasis is placed on interventions to help cope with the trauma. Two main types of intervention have been developed successfully to reduce symptoms of acute stress and prevent PTSD among those directly affected by the disaster, including first responders. The first is psychological debriefing, particularly *critical incident stress debriefing* – a single encounter designed to help the participants reorganize their thoughts and emotions following the traumatic event and make sense of what has happened. This is a group intervention that can also be provided to individuals. This intervention is usually provided in the first days after the event (24-72 hours following the exposure to trauma) (Foa et al., 2005).

The second type of intervention is short-term CBT: four to five sessions, starting two to five weeks after the exposure to trauma. It is designed for individuals experiencing a high level of PTSD symptoms and those at risk of developing chronic PTSD. Multiple randomized controlled trial (RCT) studies about this type of intervention suggest that it can accelerate recovery and even reduce the risk of developing chronic PTSD (Foa et al., 2005).

Other interventions targeted at individuals and smaller groups that were exposed to a traumatic experience, and whose goal is to reduce acute stress reactions and prevent the development of chronic PTSD, include drug therapy, whose benefit has been found to be limited (Foa et al., 2005); eye movement desensitization and reprocessing (EMDR); computerized progressive attention training (CPAT); narrative therapies; relational psychodynamic therapy; hypnosis; and somatic experiencing therapy. In Israel, several organizations use the 6 Cs model developed by Dr. Moshe Farhi, founder of the International Center for Functional Resilience (ICFR, 2020). The model is designed to enable both professionals and lay persons to provide mental first aid in stress and emergency situations. On the individual level, the model enables people to return to full effective functioning within minutes during a challenging event and reduces the risk of secondary traumatization to a minimum. On the collective level, this model can contribute to the community's resilience and independence, enabling it to care for itself during a crisis and regain control in chaotic situations.

Interventions for Coping with Emotional Distress and/or PTSD:

In the days and weeks after a terror attack, the population's emotional reaction can attenuate or exacerbate, depending on the scope of the event, the number of casualties (mainly children), the damage to infrastructures, and the response to the immediate interventions implemented after the event (Foa et al., 2005). Given that many individuals will have to cope with emotional distress, it is suggested to reach out to everyone affected by the event, whether directly affected or not, for a psychosocial assessment and follow-up (Kärki, 2015; Nilsen & Stene, 2023). Post-disaster intervention programs often include formal risk assessment to screen for prolonged grief disorder (Bensimon et al., 2023). This assessment is based on a combination of prospective evaluation and response to treatment (Harrop et al., 2020).

Common types of interventions for people coping with acute distress and chronic PTSD include exposure therapy, cognitive therapy, stress inoculation training (SIT), and drug therapy when deemed necessary or advisable. Exposure therapy, a type of CBT, has been successfully disseminated to several community clinics in the US and Israel, but despite this fact, and evidence of its efficacy, therapists are generally not trained in this type of therapy or are reluctant to use it (Foa et al., 2005). In addition, there is widespread use of support groups and a variety of emotional therapies, including less traditional approaches, such as art and animal-assisted therapy, which

are used as an alternative to traditional talk therapy and may be more effective with certain populations. These interventions are suitable for people of all ages, but adjustments must be made according to their background characteristics.

3. Standards of Practice and Best Practices

3.1 Standards for Interventions for Loss and Bereavement

Most people experience normal grief and do not require professional intervention. Obviously, however, they will benefit from encouragement, recognition of their loss, and access to information about processing the loss and sources of help and support. A small number of the bereaved developed prolonged grief disorder and require professional intervention (Irish Childhood Bereavement Network, 2017; Kissane et al., 1998). In order to take advantage of available resources and provide customized services to all those who require them, the support given must be based on diagnosis and assessment of individual needs (Agnew et al., 2010). In addition, information on interventions and services available to the bereaved must also be provided to non-therapeutic professionals, such as educators or social organizations active with a variety of populations, in order to reach out to as many people as possible.

Organizations that coordinate services for the bereaved on the national level operate according to models for ranking the needs hierarchy and allocating resources accordingly. For example, in Wales they use the National Institute for Health and Care Excellence (NICE) three-component model of bereavement support: (1) *Universal* – providing information about coping with bereavement in order to raise awareness and help individuals learn where they can find additional support, through conversations, brochures or online sources; (2) *Selective or targeted* – providing easy-to-access consultative processes to share their feelings in a variety of formal opportunities, including group meetings, peer support, friends' groups or participation in groups dealing with a specific type of bereavement, e.g., following suicide; (3) *Specific* – referral to specialist intervention programs, such as mental health programs, emotional support and professional counseling (Welsh Government, 2021). The Irish Childhood Bereavement Network (ICBN, 2017) operates according to the Childhood Bereavement Care Pyramid launched in 2014 by Dr. James Reilly, then Minister of State for Children and Youth Affairs. The pyramid guides professionals and adults in identifying and meeting the needs of children and youth coping with loss. The pyramid emphasizes the role played by the family and community in supporting bereaved children and youth and that treatment be provided in the family context and in accordance with the child's developmental stage.

Organizations that provide interventions for loss and bereavement need to ensure that the services they provide meet quality standards. The following are standards for best practices that organizations should adopt in order to offer quality services to the bereaved.

- **Competency** – Professionals and organizations providing bereavement support services should be familiar with the current literature, research, and best practices. They must be fully informed on recent developments in the field and have rich and broad knowledge of the field and related disciplines (National Alliance for Children's Grief (NACG), 2013).
- **Training and supporting volunteers** – Organizations that rely on volunteers need to maintain high standards, and must therefore provide their volunteers with on-going education, training, evaluation, support, and a code of conduct. The organizations must enforce a strict policy of reporting by, and assessment of the staff members and volunteers based on the local and national laws applicable to people working with minors. This policy must protect children and their families against inappropriate care and abuse, and the staff members and volunteers against unjust accusations (NACG, 2013).
- **Adapting services to the background, characteristics and needs of the bereaved** – The services must be adapted to the age, gender, religion and religiosity, and sociocultural norms of every individual (Millar et al., 2020; Welsh Government, 2021). Cultural, ethnic, economic, religious, and sexual orientation diversity must be acknowledged and respected in order to remove barriers to service provision (NACG, 2013; Shalev et al., 2021).
  - *Religion and culture* - The cultural background of the bereaved has a significant influence on their coping with bereavement. Ethnic and religious groups have traditions regarding the meaning of death and bereavement and the way individuals and families need to cope with them, and these traditions may serve as assistance mechanisms for coping with grief and processing information. (Shalev et al., 2021). Cultural and religious adaptation should be manifested in the way professionals address the bereaved and shape the relationship with them, as well as in showing cultural sensitivity to their rituals and religious practices (Rubin et al., 2016; Stroebe et al., 2011). It is also relevant in deciding on the meeting place – treatment at home should be offered if coming to the organization's location can be a barrier to accessing the service (Shalev et al., 2021).
  - *Needs and time frame* - There should be an awareness of individual needs, and of the possibility that the bereaved will seek support more than once after the loss, even years later. Moreover, services should be offered in a variety of languages, including sign language and Braille, or by other means for those with visual and hearing impairment (Welsh Government, 2021).
  - *Gender* - Support must be adapted to the gender of the bereaved, given the different bereavement experience of women and men – their different emotional reactions and the different ways they express difficult emotions; their difficulties at work; their reliance on the extended family; the nature of their

relations with their children; the nature of their relations with the deceased; and their ways of coping with the loss (Alam et al., 2012; Doka & Martin, 2011). Among children, studies found that girls tend to be more introverted, whereas boys are more extroverted; in bereaved families, girls tend to assume parenting roles more than do boys, a fact that affects their development (Haine et al., 2008).

- *Age: Children* - Intervention programs for bereaved children need to take the following into account: (1) the cause of death; (2) the time since death; and (3) the child's developmental stage. Studies on interventions with orphaned children indicate that relatively brief interventions provided shortly after the loss may prevent the onset of emotional problems among children and adolescents (Weber et al., 2021).
- *Age: Older adults* - Intervention programs for bereaved older adults need to take the following into account: (1) The experience of previous losses that makes death a constant presence in their lives, and may also affect the way they perceive their own lives; (2) The perception of loss as affected by a retrospective perception of the meaning of life, the ideological and family meaning of ones' life work, etc. Among older adults, national meaning plays a major role. The members of the first generation of Israeli independence have experienced a huge crisis of faith following the October 7 attack (Aisenberg-Shafran, 2023; Malkinson, 2023); (3) The perception that time is short and insufficient for processes of recovery and rebuilding a new future. Precisely for that reason, it is important for older adults to be full partners and bear full responsibility for these processes, with emphasis on their past achievements, values and life experience; (4) Older adults as the historical experts on their lives, bearing joint responsibility for working through their grief, while identifying strengths and resources available and the meaning provided by life in the past and articulating them in the therapeutic process, hand in hand with the therapist's expertise (Aisenberg-Shafran, 2023; D. Aisenberg-Shafran, personal communication, January 2024).

- **Emphasizing availability and immediacy** – The services must be available to all bereaved individuals. Treatment may be provided face-to-face, over the phone or online (Breen et al., 2018; Ridley & Frache, 2020). The interventions should be available within a reasonable time. Delay in treatment can lead to the development of prolonged grief disorder and other emotional difficulties such as depression and anxiety, as well as to behavioral issues such as alcohol and drug abuse and self-harm. Suicide risk can also increase. Among children and youth, the lack of availability of treatment could lead to risk behaviors and behavior problems, including truancy, eating disorders and mental disorders (Welsh Government, 2021).
- **Strengthening multidisciplinary systems and a continuum of preventative services** – Multidisciplinary systems and continuity of treatment enable the provision of support to children and youth coping with loss

at the proper time and by the appropriate experts (Millar et al., 2020). Guidance on grief and trauma should be provided to parents and providers of secondary services, such as schools, health services and volunteers, to improve the systems' response capability and extent of services (Griese et al., 2017). Effective collaboration between medical services (hospitals, health plans) and community services (schools, non-profits) is important for reaching out to the bereaved and recruiting them into intervention programs (Ridley & Frache, 2020). Ways of establishing multidisciplinary networks and service continuity include state funding for services or ensuring insurance coverage regardless of diagnosis.

- **Advocacy** – Service providers are encouraged to engage in outreach in their local communities to increase awareness of issues that affect bereaved families (Griese et al., 2017; NACG, 2013). National policy and local infrastructures must be developed to meet the diverse needs of bereaved persons (ICBN, 2017). These activities should also be directed at increasing the awareness of health and education professionals, as well as members of the community in general, in order to widen the access to services (Ridley & Frache, 2010).

3.2 Approaches to Treating Loss and Bereavement

Grief involves both an intra- and interpersonal process. These processes affect and are affected by each other and involve a reprocessing of the relationship with the deceased and the relationships with the family members still living, and a reorganization of life without the deceased (Kapulnik and Refael-Ashuri, 2019). When intervention and support are offered to bereaved families, both the individual and the family should be taken into consideration, since their feelings and the circumstances overlap, but do not completely match (Breen et al., 2018).

The basic premise of models and programs for coping with loss and bereavement is that grief and adjustment to loss are natural responses, and that every individual can adjust to loss given the right support and treatment (Griese et al., 2017). The understanding is that every individual can offer themselves non-judgmental understanding, grace, and self-compassion in moments of pain and failure, humanity, and mindfulness, and that each individual can view the continuity of the relationship with the deceased as an integral part of the process of grief and grieving (Patterson et al., 2021). The literature describes a wide variety of intervention programs in this area, from education for grief and provision of coping strategies, through group support and sharing, to therapy. The most common theoretical frameworks in those models and programs are developmental theory, CBT, trauma-focused treatment, expressive treatment, and family bereavement programs (Ridley & Frache). The following are some of the most common types of intervention suitable for people of different ages:

- **Family-oriented interventions** – The family is the main and natural source of support in times of crisis and loss (Kissane et al., 1998; Millar et al., 2020; Ridley & Frache, 2020; Schuler et al., 2012). One of the major approaches in treating the bereaved is support for grief as a family process (Millar et al., 2020). Providing a family-centered intervention may be challenging because of the difficulty of evaluating it as a unit of treatment. The self-definition of the grief experience of each family member, and their different desires and needs for joint support must be respected. Information must be offered to the entire family, but also to each of its members separately; likewise, the entire family should be met with, but also each of its members should be met with separately (Genset et al., 2021; Griese et al., 2017).
    - *The Family Bereavement Program (FBP)* is one of the most implemented and studied family-oriented intervention programs. It is a preventive program for children and parents based on a conceptual framework of resilience, in the context of family adjustment to the loss of a parent (Sandler et al., 2013). FBP serves a wide variety of needs using diverse methods (Haine et al., 2008). The adjustment process enables the parents and children to provide for their basic needs and complete tasks that are aligned with their developmental stage in the new family structure formed after the loss. The term basic needs refers to safety and biological integrity, positive self-evaluation, a sense of control, and significant and supportive relationships (Sandler et al., 2013). The program is based on twelve parallel group sessions, for the children and parents separately.
    - Stroebe and Schut's (2015) *Dual Process Model* takes into account both the experience of loss and the experience of change (recovery), and the *Dual Process Model-Revised* (DPM-R; Stroebe & Schut, 2015) is an extension of the dual model, based on a more structured conceptualization of individual-family coping. The model examines the way coping with loss and recovery is manifested on the individual and family levels, in order to bridge the huge gap created between the individual and family approaches in coping with loss and recovery, and offers an intervention that meets both individual and family needs, based on the view that the whole is greater than the sum of its parts.
    - *The Family System Model for the Treatment of Loss* is based on Bowen's (1978) family system theory, which deals with multigenerational emotional functioning and identifies two dimensions in self-differentiation: the intrapersonal dimension, or the balance between the cognitive and emotional systems that enables individuals to think in a way that differentiates between emotion and thought; and the interpersonal dimension, or the ability to balance the individual and family to maintain individual differentiation and autonomy in relationships. The higher the level of differentiation and the lower the level of chronic anxiety, the better the individual and family's coping with psychological pressures. This model is based on three

axes that must be reflected in planning the intervention: *the development axis* – the role of each of the members in the family system and the disruption caused by the loss to their natural development process; *the loss axis* – the meaning of the loss for each of the family members and the type of grief experienced by each – normal or pathological (delayed or prolonged); and *the therapist axis* – where the therapists are required to assess their ability to contain the variety of voices emanating from the family (Kapulnik & Refael-Ashuri, 2019).

- **Meaning in Loss (MIL) therapy** – It was found that finding new meaning in life is related to successful readjustment after loss (Lichtenthal et al., 2011). According to Neimeyer (2000), the process of discovering meaning is mainly about accepting the loss and the circumstances of death, finding a new purpose in life, and redefining one's self-identity. The MIL approach draws on the principles of narrative therapy and is designed to promote the formation of new and adaptive ways to integrate the experience of loss and to compassionately reconnect with the deceased. This approach is often integrated in intervention programs, usually as a component in a more general program for treating loss and bereavement. The MIL therapy intervention can be implemented in 12 to 14 face-to-face or online group sessions organized in a sequence of meaning reconstruction phases (Mental Health Technology Transfer Center Network, 2020).
- **Prolonged Grief Treatment (PGT)** – The Center for Prolonged Grief at Columbia University (n.d.) has developed a 16-session intervention with two aims: (1) Restore the functioning of the bereaved persons and help them adjust to their loss; (2) Identify and treat points where the bereaved individuals are "stuck" so that the thought of death does not cause intense feelings of anger, guilt, or anxiety. The intervention includes seven milestones to healing: understanding grief, emotional management, positive thinking about the future, enhancing relationships, telling the story of the death, learning how to live with family members, and preserving the memory of the deceased. The sessions are structured like CBT sessions: at first, the agenda of the session is presented, followed by focus on the loss and focus on recovery, followed by plans for the next week. The intervention is individual, but studies show that it can also be adapted to group therapy. This intervention model has been extensively studied, and it is the first intervention found effective in treating prolonged grief disorder. The Center for Prolonged Grief has also developed diagnostic tools, available for purchase on its website.
- **Cognitive Behavioral Therapy for Grief** – This is a focused approach based on the premise that thoughts influence feelings and behaviors, which in turn can influence cognition. An intervention based on CBT will act to encourage acceptance of the loss, modify maladaptive grief-related appraisals, and reduce avoidance behaviors that maintain pathological grief reactions. The approach relies on four core treatment interventions: learning normal and prolonged grief processes; exposure to the most painful aspects of the loss; restructuring

of the loss to enable change; and instilling grief-appropriate behaviors that will help the bereaved person re-engage in previously meaningful activities. The intervention is both individual- and group-based, and usually includes 12 sessions (Mental Health Technology Transfer Center Network, 2020).

- **Grief and trauma intervention for children** – This treatment is designed for children aged 7-12 who are experiencing symptoms of grief and post-traumatic stress following a death, disaster, or act of violence. The intervention is conducted with children in a group or individual format in ten one-hour sessions with at least one session with the parent. The sessions use techniques borrowed from CBT and narrative therapy, and include narrative exposure to the trauma through drawing, discussing, and writing, developing an in-depth, coherent narrative while eliciting the child's thoughts and feelings, developing positive coping strategies, and giving meaning to the loss (Hagan et al., 2017; Mental Health Technology Transfer Center Network, 2020). The intervention is usually implemented in schools or through community services, so that it also includes one session with the education staff in the child's school. The children are rewarded for skills practiced at home between the sessions, and each session ends in breathing exercises and a ritual, if the group has developed any. Multiple studies found that this intervention reduced PTSD symptoms among children coping with the loss of a loved one following homicide or a disaster, such as Hurricane Katrina. One study found a significant reduction in anxiety and considerable improvement in social support, which continued for a year after the end of the program (Hagan et al., 2017).
- **Counselling and psychotherapy for older adults** – Supportive counselling can help older adults benefit from a wider range of social support, acquire new skills, and normalize the mourning process. The main goals of the counselling are to provide comfort and support, relieve grief, attenuate sorrow, and adjust to the new situation. The intervention can be especially helpful for socially isolated populations and people at risk for mental problems or the development of prolonged grief disorder (Hooyman et al., 2021). Due to the characteristics of loss among older adults, it is feared that some will develop traumatic loss, that is, prolonged grief disorder combined with PTSD symptoms. Factors that can impair the mourning process must be identified, including traumatic circumstances (type of disaster, type of exposure to the disaster); previous losses; insecure attachment to the deceased; personality characteristics; lack of support systems; and additional non-death losses (Malkinson, 2023).
- **Support groups** – Relating to another bereaved person can reduce grief symptoms and increase wellbeing and personal growth (Mental Health Technology Transfer Center Network, 2020). Therefore, we find many support groups active around loss and bereavement. In Israel, there are groups active on behalf of the Ministry of Defense, the National Insurance Institute, the Ministry of Welfare and Social Affairs, and various NGOs, such

as Selah, which supports new immigrants. Support groups are intended for all family members, including children who have lost a parent and grandparents who have lost grandchildren. For example, the Department of Senior Citizens in the Municipality of Kfar Saba offers a support group for grandparents bereaved as a result of the Israel-Hamas War. Other groups for older adults have been active for several years, providing them with tools for coping with bereavement, giving them meaning, and helping them understand their role in the family bereavement process (Segev Rosenberg, 2016).

- **Peer support** – This is a strategy that helps normalize the feelings of bereaved persons regarding their loss and adopt coping techniques (Millar et al., 2020). An example is the bereavement program active in St. Jude Children's Research Hospital in Memphis. The program was created with the inspiration and leadership of bereaved parents. It offers parents who have lost a child extensive support services and resources, with three main emphases: (1) Therapeutic intervention and support services, such as parent-parent mentoring, memorial services, and a kit developed by a team of psychologists with the help of bereaved parents to cope with particularly difficult days. The kit includes a list of institutional support resources, FAQs and recommendations on how to talk with the child and others about the end of life. (2) Materials for supporting the bereaved designed by the parents, such as sending a consolation card to the family several weeks after the loss. Attached to the card is a postcard where the parents can state which materials, resources and contact details of support sources they would like to receive, or a book that marks dates that can be particularly sensitive for the family. (3) Parental participation in training, such as staff training, or in studies designed to expand the understanding of the parents' and families' bereavement experience (Snaman et al., 2017).
- **Spiritual care** – Individual treatment should be holistic and should also include a spiritual and religious dimension when the individual is interested. Spiritual care is directed to more than the immediate physical illness, limitation, suffering or grief (Welsh Government, 2021). Spiritual care is a person-oriented intervention that helps individuals identify their spiritual resources and enhance them so that they can serve as an anchor in time of crisis. It is designed to help people maintain their personal identity under threat and create meaning and hope in conditions of loss and distress. This therapeutic approach has developed in Israel in settings that address mainly end-of-life, illness, and crisis situations. In recent years, it has also been used to treat additional populations in the community and help cope with trauma and crisis, loss and bereavement, and transition stages in the overall cycle of life. Since 2016, spiritual therapy is one of the services offered in support centers of the Makom Lanesha(i)ma program (Breather-for-the-Soul Space). A study conducted by the Brookdale Institute sheds light on the implementation of this intervention in the centers' work and its contribution to individual and family wellbeing and behavioral-functional change (Milstein et al., 2020).

4. Summary and Recommendations

In the wake of mass-casualty disasters, countries worldwide implement policies designed to meet the needs of those directly impacted, as well as the general population, in order to cope with the effects of the disasters. This review was designed to help policymakers and professionals plan their interventions with families and communities coping with trauma, loss, and bereavement, in both the short and long term. We reviewed guidelines recommended by the literature following mass-casualty disasters and best practices for interventions with loss and bereavement. Nevertheless, it should be noted that even the guidelines and programs found effective must be reexamined according to the context, and be adapted to the situation and location, on both the individual and the systemic levels. In the present situation in Israel, this is all the more relevant, as we are in uncharted territory, which challenges familiar definitions of treatment of trauma and loss and requires creativity and flexibility in planning and providing interventions. Based on the review, we have formulated several recommendations for coping with the impact of the terror attack of October 7, 2023, and the ensuing war:

- **Develop a systemic approach to coping with trauma, loss, and bereavement**: A mass-casualty terror attack challenges the service system's ability to provide services, both because of the need to provide services to a large number of people and train dedicated teams for that purpose, and because of the need to coordinate these actions over time and ensure effective and continuous cooperation between different services countrywide. On the systemic level, each system must develop intervention practices within the purview of its own responsibilities and use existing infrastructures and strengths. On the individual level, we recommend appointing a case manager to coordinate the interventions provided to individuals and families to make sure all needs are known and met.
- **Strengthen the health system**: The health system is obviously essential for protecting the population's health and wellbeing and must therefore be provided with the capabilities to respond in an emergency as well as it responds in routine times.
- **Direct national resources to local authorities**: One of the arguments made in the literature is that government agencies find it difficult to provide effective aid in the wake of a disaster. It is therefore important to strengthen the local authorities' abilities to provide the services and support required, and to rely on private and non-profit organizations as well. The central government must allocate the necessary resources and direct budgets to rehabilitation activities and intervention planning, whereas local authorities and private organizations and NGOs are responsible for implementing the policies and programs according to local needs.

- **Attend to changing needs and plan accordingly**: An immediate response to a disaster can have a decisive effect on the physical and emotional wellbeing of those directly and indirectly affected. In the first stage, physical and mental health first aid and rescue should be provided quickly. In the following stages, a proactive approach must be adopted, and mechanisms must be established for early identification of risk factors for mental disorders, as well as to provide preventive treatment. These mechanisms should include professionals from a variety of areas, as well as community services and workplaces to ensure that no need is left unmet.
- **Provide interventions according to need, and on several levels**: To effectively utilize available resources and provide customized services for all those in need, support must be given based on individual diagnosis and assessment, and flexibility must be shown in adjusting the service for each individual. At the same time, it is imperative that support services are available within a reasonable period of time. Delay in providing treatment could lead to the development of PTSD, prolonged grief disorder, and other emotional difficulties, such as depression and anxiety, and to behavioral disorders, such as drug and alcohol abuse, and self-harm. In developing interventions, it is important to evaluate the effects of the disaster on the mental health of those directly affected, as well as on those exposed to them or living near them, and to provide treatment adjusted to the three circles of affected individuals in order to reduce the risk for complex post trauma.
- **Allocate resources and adjust interventions for high-risk populations**: Some groups are considered particularly vulnerable in disaster situations: minorities, people with low levels of education, people who have been traumatized in the past (such as Holocaust and war survivors), new immigrants, women, evacuees, people with a history of mental disorders or who are in treatment for mental health disorders, children, and older adults. Professionals and policymakers must be aware of the vulnerability of members of these groups to assure that special budgets are allocated to them, and that the interventions they receive meet their needs.
- **Adapt the intervention to the culture and age of special groups**: Bereavement in childhood involves unique challenges. Their bereavement is not continuous, but manifests itself intermittently along the stages of emotional and cognitive development in childhood. Therefore, programs must be offered over time, according to need. In intervening with children, it is important to combine relaxation activities with grief-processing activities. In intervening with older adults, it is important to account for the meaning dimension as central to the perception of loss and treat the person's life history and experience as a major resource in the process of personal, community and national rehabilitation. Such processes need to take place while engaging the older individual in the decision-making process and the manner in which the intervention takes place.

- **Train professionals**: Professionals' preparedness for dealing with mass trauma, loss, and bereavement is key to ensuring effective interventions. Professionals must be familiar with these areas, their expertise must be up-to-date, and their knowledge rich and broad. Accordingly, they must be provided with opportunities for professional development and dedicated training.
- **Expand the circle of help and support**: The need to treat and support many people means that it is impossible to rely on professionals alone. Several actions may be taken to expand the number of providers of help and support. First, private therapists must be recruited in addition to those employed in public services providing support for trauma and loss. Second, when providing non-therapeutic aid and support, a variety of people can also help: (1) Mental health professionals need to train professionals from a variety of areas, including educators and members of community support systems, including religious leaders and community representatives, in identifying symptoms of acute distress, and should provide them with information about support mechanisms and available services so that they know where to refer those in need; (2) After a disaster, family members and neighbors do their best to help members of their community, and they should therefore be considered a resource and be included in aid and rehabilitation efforts – for example, in organizing social activities, in providing information, in listening, and in providing instrumental help; (3) The family is the natural and main source of support in times of crisis and loss, and therefore, family members should also receive guidance in coping with grief.
- **Implement community intervention models**: Trauma is etched in the community's shared memory and affects the collective identity and community fabric (Sarig, 2017). Therefore, if the entire community has been affected, its members must regain a sense of order, control, and self-efficacy, as well as rewriting their narrative. In the present reality in Israel, in which entire communities have been affected, we recommend implementing a community intervention model and adjusting it to the strengths and characteristics of each community.
- **Provide group interventions and complementary support tools**: Many types of interventions in the areas of trauma, loss and bereavement are suitable for group therapy, enabling them to reach out to more people. Support groups are also recommended when coping with bereavement. Another approach to support bereaved persons that does not require investing large resources is peer support. This strategy helps normalize the bereaved persons' feelings regarding their loss and to adopt coping techniques. Peer support approaches include parent-parent mentoring and providing a kit for coping with particularly difficult days, which includes a list of formal sources of support, FAQs, and recommendations on how to talk with family members and others about end-of-life issues.

- **Provide meeting spaces**: In order to identify people in great need, they must not be isolated, but rather, should be in contact with others. Therefore, we recommend establishing centers where people can meet. These centers must be operated by professionals, along with semi-professionals and volunteers. The centers can be used both for mutual support and sharing and for providing reliable information to family members of casualties and survivors. They can also be used for coordinating interventions to meet the affected individuals' psychosocial needs.
- **Use the mass media to disseminate reliable information and build up resilience**: One of the most important resources for developing national resilience is providing reliable information to the public. This reduces uncertainty and increases self-efficacy. In addition to communicating the situation to the public, the media can be used to provide instructions on relaxation, meditation, and guided imagery for regaining a sense of control, and provide practical advice regarding media consumption (such as reducing exposure to video clips and photos of the disaster). To facilitate this, there is a need to educate and monitor the media and even encourage them to make use of mental health consultants. Government authorities and civil society organizations can mediate the existing resources through the media and encourage the use of services and programs to help cope with the disaster.
- **Increase awareness of trauma, loss, and bereavement**: Professionals and policymakers need to increase awareness of issues affecting individuals coping with trauma and bereaved families, on both the national and local levels, and promote policies and initiatives for meeting the diverse needs of bereaved persons and make appropriate services available.

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