Learning from a decade of terror in European cities: Immediate, intermediate, and long-term follow-up

Even though terrorist attacks are diverse, several common lessons can benefit the psychosocial response following future terrorist attacks, write Atle Dyregrov and colleagues.

PSYCHOSOCIAL RESPONSE: Following terrorist attacks, leadership and chain of command must be as clearly defined in the psychosocial area as they are for emergency responders, write Atle Dyregrov and colleagues. This photo shows the 2012 ceremony commemorating after the terror in Norway 22th of July 2011. Photo: Office of the Prime Minister, Norway.

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+ Abstract

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This article presents lessons learned about the organisation and provision of psychosocial support in terror-stricken European cities. The information is based on the experiences of professionals directly involved in organising and providing psychosocial support and of representatives from peer support organisations[1] (PSOs) formed in the aftermath of the terror events. These psychological spokespeople were gathered for a workshop to discuss lessons learned. (See Method section.) By describing the opportunities and difficulties in responding to these events, we hope that future responses to terror events can be improved.

In the last decade, a series of terrorist attacks has taken place in various cities in Europe (e.g., Paris, London, Manchester, Oslo). The terror has taken different forms, from bomb explosions and vehicle-ramming attacks, to mass shootings and knife stabbings. The casualties have varied widely from a few to more than a hundred people killed as well as small to vast numbers of injured. While some situations involved a single bomb explosion, others led people to hide or flee for hours to stay alive. The degree of threat to life, the duration of the event, and the latency before help arrived have thus varied, making the psychological toll on survivors, the bereaved, helpers, bystanders, and the public diverse. The systems in place to assist in the immediate and long-term phases have varied from country to country, both in terms of medical emergency response (more homogeneous) and mounted psychosocial response. Psychosocial support during emergencies usually refers to interventions that aim to reduce psychological distress by attending to people's psychological and practical needs following a crisis or disaster event.

Responses must be understood in relation to context because different response systems have developed separately in different countries (Kuipers, Boin, Bossong, & Hegemann, 2015). Despite these differences, similarities also exist due to harmonisation through EU-regulations (Ibid.), and in March 2019, the new legislation entered into force to strengthen financial and operational support, including rescEU that represents reserve capacity for transnational help (https://ec.europa.eu/cyprus/news/20190521_en). Terror events in major cities are transnational because they affect people visiting from many countries. Thus, a high demand exists for collaboration between professionals and systems in several countries. Such collaboration would be achievable through good relations between

the professionals involved and governmental authorities in charge of the follow-up.

Every terrorist attack represents possibilities for learning from the event which could benefit the next city to face such an attack. This article sums up and discusses lessons learned from the psychosocial responses following recent terrorist attacks in European cities.

Method for extracting lessons learned

In 2018, the first author invited representatives from ten European cities that have experienced terror since 2011. This includes all cities where the deadliest attacks (https://en.wikipedia.org/wiki/Terrorism_in_Europe) took place. Participants from two cities (Paris and Brussels) unfortunately could not take part. Representatives from Oslo, Berlin, Barcelona, Turku, Nice, London, Stockholm, and Manchester participated in the workshop in October 2018. Those present either had a central role in organising the psychosocial follow-up or they represented peer support organisations(PSOs) formed by those directly affected (user representatives). Participants were sought through contacting NGOs, governmental organisations, and people who had published about psychosocial follow-up in a terror-affected city and from asking for persons central to the psychosocial organisation and follow-up. Two representatives participated from most cities, but only a few cities had established PSOs. Representatives for three PSOs were present. Ahead of the workshop, representatives wrote a short “Lessons learned” summary (1 to 6 pages) about the psychosocial response. During the workshop, two discussants (two first authors) led a discussion that focused on three phases of follow-up: the immediate < 1 week; the intermediate (>1 week to 1–2 months), and the long-term (> 2 months). The lengths of the immediate, intermediate, and long-term follow-up phases are based on what participants usually indicated. Notes from the discussions and lessons learned documents form the basis of this article. In addition, all participants have had a chance to comment on this manuscript.

Lessons learned: Immediate response

The unpredictability and varied nature of the events made for a vast span of different responses. The assistance had to be adjusted according to the situation, demanding flexibility in where and how victims were met. Telephone hotlines, temporary next-of-kin centres, or reception centres were set up but varied in where and how they were organised. For example, after the Utøya terror, a nearby hotel was quickly organised to help survivors and family members who gathered near the island. In Turku, they also established reception centres for “it could have been me” groups. In other situations, like in Barcelona and Stockholm, many people were trapped inside shops, storerooms, and cafés, where they stayed for hours until the situation was stable. In Barcelona, around 5,000 people were confined for at least five hours. In Manchester, the families of the missing and presumed dead were gathered at a pre-allocated Friends and Family Reception Centre at the local football stadium. They were later accommodated in a hotel near the mortuary, where they waited for news as to whether their family member had been identified as one of the deceased.

Registration of affected persons was often impossible or haphazard under such chaotic situations. To some extent, lack of registration at the outset was due to an initial lack of registration facilities. Askenazy and co-workers (2019) described this scenario as an "initial disorganisation of administrative procedures" when an influx of patients were received at the emergency ward in Nice within the first hour following the attack there. In such chaotic situations, reunifying family members becomes a priority (to alleviate, for example, frantic parents searching for their children). Professionals in Nice have therefore recommended a computerised data processing system with trained personnel for registration in such contexts (Chauvelin et al., 2019).

Obtaining information about those affected was a recurrent problem in the immediate phase. Such particulars ranged from information about missing family members to information about what happened, where to receive help, etc. Frustration and anger were observed among those desperately trying to locate their family members. The Police Casualty Bureau helpline in Manchester, intended to assist those looking for family members in the hours and days after the city's bombing, did not function as planned. The system from the telecommunications network provider not working (https://www.kerslakearenareview.co.uk/documents/) gave rise to this dysfunction.

In several cities, the lack of registration of people added to the problems. When information from authorities was insufficient, rumours flourished and people depended on the media, though the reliability of this information varied. Privacy matters restricted information sharing in hospitals and created problems for those searching for details about their family members. Close collaboration between police and those responsible for psychosocial care is necessary to secure close and regular contact, which facilitates information flow in both directions. Such a joint effort worked well in Manchester with the police sharing information with the statutory NHS psychosocial provider of persons they were concerned about. In turn, the NHS psychosocial responder directed potential witnesses to the police. An important part of psychosocial care is to obtain verified information at the earliest possible time. Information is needed on the current situation, on where to access up-to-date and verified information, on where to receive help, on where to get assistance with practical issues, and on the rights affected people have. Regularity in information sharing with those affected, even if it does not add much to the factual knowledge about the situation, contributes to a feeling that the authorities are in charge and doing their utmost to support the families of the survivors and deceased.

In Stockholm, the terror highlighted the need for one permanent psychosocial hotline number. Several cities noted the necessity for better registration forms to use during the incident and thus improved their record-keeping procedures. It should be remembered that registration of presence at an attack may become an issue later if problems arise as a consequence of exposure (e.g., regarding legal or insurance matters). In the Swedish capital, a need also existed for different language versions of information leaflets available. Social media became both a blessing and a

challenge, making it possible for people who got separated to renew contact. But it also created additional shocks for people who understood that their family members were dead based on photographs circulating on the Internet. In such situations, extensive use of social media can also add to the stress of the situation (Goodwin, Lemola, & Ben-Ezra, 2018).

Lack of coordination was the major problem encountered in many of the cities that were terrorised. When terror is transnational, coordination of help becomes crucial. One example of how problematic this synchronisation can be arose when a team was flown in from an outside country to help people from a particular organisation from the team members' home country. The local authorities tried to engage members of this team to help translate for other citizens from their homeland but they declined because they were there only to help their own organisation.

The problems with coordination must be seen in light of the number of affected people. In Nice, for example, it was estimated that 50,000 people were in the street where the terrorists' truck hit pedestrians. In Barcelona, there were 15 causalities but a total of 1,200 people were assisted with acute stress responses. In Manchester, more than 15,000 people were present at the concert the terrorists targeted.

While available crisis contingency plans may be made at different levels (i.e., from the government, from county councils, and from local municipalities), the knowledge of such plans varies, making coordination and collaboration difficult. If one adds the variations of different names, concepts, and terms used in these plans, collaboration and effective crisis support are further impeded. The level of response is also directly related to the amount and regularity of exercise, both tabletop and in vivo exercises. In the case of Utøya, Hole municipality had an emergency plan in place as well as an updated overview of the collective resources available in both municipal and specialised services.

The use of translators becomes a necessity when different nationalities are present. Planning how to deal with different languages must be part of every disaster plan. The psychological toll on translators can be heavy, especially when they are not trained or used to encountering people in emergencies. Preplanning of contact with embassies and consulates, and preferably a meeting in advance to clarify roles, will ease future collaboration. This foresight can secure support for victims from their home country. In several of the terrorised cities, it was unclear who would cover travel costs for close relatives to visit the injured or be with their dead loved ones.

In some cities, collaboration was strained between crisis centres and hospitals, making it difficult for interaction to take place between injured and uninjured survivors. In several affected cities, overlooked groups were identified (e.g., foreign visitors, asylum seekers with a previous history of trauma, witnesses and "it could have been me" groups, and people who had been in contact with the perpetrators before the terrorist attack). Where children and adolescents were survivors or victims, the need to provide for them and their families from the start was emphasised (cf. Askenazy et al., 2019). However, children may be difficult to reach

and preplanning on how to achieve influence over them would be helpful. In such cases, outreach becomes paramount. Manchester psychosocial responders provided information and support to schools and colleges in addition to performing direct child and family work. Advice to parents with children was also provided, which included the importance of maintaining regular routines, in Nice for example (Askenazy et al., 2019).

The number of volunteers and informal helpers was highly valuable in many cities but also represented a problem in the immediate phase. Coordination became difficult, even impossible, due to the lack of both a lead agency and a strategy for how to make use of those who volunteered. In several impacted cities, the sheer magnitude of helpers arriving became a problem because their skills did not always match what was needed. In some cases, the volunteers had inappropriate, harmful, and/or exploitative approaches (e.g., deep emotional conversations with survivors right after the event) and caution regarding such approaches should be made during future terror events. Also, too many volunteers strain the system, with irritation growing among them if there is no role to fill. A system needs to be set up ahead of time to ensure better coordination, regulation, and use of resources. A lead agency for volunteers is strongly recommended.

Interaction and coordination of psychosocial and medical assistance, including the chain of command, can also prove challenging. Regarding psychosocial first aid, involved personnel should possess basic knowledge of how to help.

Informal helpers are not part of a professional organisation or non-governmental organisation (NGO) that has a system in place to follow up with its personnel afterwards. In the immediate phase, registration must be in place for all involved helpers to facilitate later contact. After several of the terror events, critiques have been made regarding follow-up on the voluntary helpers. From studies, we know that such helpers are usually worse off than professional helpers (Gjerland, Botha Pedersen, Ekeberg, & Skogstad, 2015). In many of the affected cities, helpers were taxed during the initial phase, making it difficult for them to step back. That is because the “high” of being part of important work can prompt them to overextend themselves. A maximum number of volunteer hours or days has to be set by leaders and not by individual choice.

The involvement of the government following the terrorist attacks varied. In Norway, the government developed a national model in close collaboration with support groups, professional experts, and different organisations representing professions and communities, among others. However, this approach mainly affected the intermediate and long-term follow-up. A small community held responsibility for the immediate intervention following the Utøya killings. This scenario tested personnel in the early phase, and the government had to step in to supplement resources. The level, or lack, of governmental involvement also caused resentment in other cities and is an issue that should be given attention to reduce additional stress in future acute situations. There is also high symbolic value in

having political and/or royal leaders provide national recognition by visiting the scene of the terror event and meeting both those affected and their helpers.

No internationally recognised protocol exists for how to care for people in the immediate phase. The role is different from ordinary work at hospital wards or in the community due to the sheer intensity and number of victims. As Askenazy and co-workers (2019) write, "… mental health professionals should know how to simultaneously promote safety, calming, and positive emotions, without being intrusive or appearing judgmental. They should also assess the need for a more formal therapeutic intervention and its degree of urgency" (p. 7). Such situations demand both proper training and preparation as well as follow-up after the work is done.

While some of the groups affected by the terror are easy to identify, there are other more "hidden" groups. After the bomb explosion in Oslo, for instance, a group that experienced "survivor guilt" was those not at work when the bomb was detonated. In Barcelona, three hidden groups were identified: a) illegals living in Barcelona who were reluctant to seek help; b) the community where the terrorists came from, including those who had worked with them; and c) the spontaneous helpers who provided first aid. This last group felt hurt by not being invited to memorial services and receiving no medals or recognition. At Utøya, the spontaneous helpers on board boats, who took part in rescuing youths in the water, had similar feelings of being overlooked. In Turku, a group of people who felt like "it could have been me" also required help, and the amount of witnesses in some terrorised cities was high. Also, in some cities it was reported that people in the Muslim communities were afraid of leaving their homes due to threats, violence, and hate crimes perpetrated by people blaming all Muslims for the attacks.

Lessons learned: Intermediate response

The intermediate and long-term responses overlap. In several cities, planning started early to secure psychosocial follow-up over time. In Norway, for example, the government had the ambition to develop a national model and gathered representatives from the school sector, trade unions, health services, county governors, municipalities, NGOs, and PSOs. The chosen officials mounted a proactive outreach with input from professional centres involved in grief, trauma work, and research (Kärki, 2015). Since those gathered at Utøya came from all over Norway, municipalities around the country were given a primary role in establishing contact with the affected families. The government also supported capacity building within mental health services to meet the new demands, and gatherings for personnel from affected schools were arranged to support the assistance efforts. Thus, the government, through the Norwegian Directorate of Health, assumed an organisational role in the intermediate phase to secure follow-up over time. By enlisting agencies from many sectors of Norwegian society, government officials assured that a consensus existed about the help being planned and offered.

The support group formed by survivors and the bereaved could correct the remote

perspective and provide the government with a more realistic or updated picture of the situation. Both then and in later follow-up, the feedback from the PSO was invaluable in ensuring that those who struggled received qualified help. In Norway, the PSO formed after the terrorist attack has continued to play an important part in making the government more aware and in prompting an adjustment in follow-up of both survivors and the bereaved. Although the communities themselves have stated that their systems worked well, the PSO's user perspective has been an important corrective voice, bringing forward information that the situation was not as optimistic as the authorities perceived it to be.

Although they were met with respect and acquired contacts in the community, health services did not meet the problems arising over time that required more trauma- and grief-specific follow-up (Dyregrov, Kristensen, Johnsen, & Dyregrov, 2014). Many young students moved from their home to university cities, experiencing a lack of coordination of services following their relocation. The PSO identified such issues and worked with the authorities to improve the matter. However, to our knowledge, few European cities that have experienced terror have had formal organisations (PSOs) formed to care for the user perspective. In the future, we would recommend authorities to support the establishment of such initiatives. A suggested framework for accomplishing this aim could be a formalised agreement to support the establishment of a peer group with a credible third party. In Norway, the Directorate of Health has had, for many years, such an agreement with the Norwegian Red Cross.

People affected by terrorist attacks often express a strong desire and need to meet others in the same situation. Peer Support Organisations can meet such needs and can mobilise mutual aid. Together, they form a shared identity with strengths and resources they do not have alone (Drury et al., 2019). Peer support, involving group facilitation by professionals, was also organised following the Manchester bombing, whereby people meet in groups across northern UK.

The hand-over from those involved in immediate help to those responsible for intermediate and long-term follow-up proved problematic in several regards. This snag resulted partly from a lack of good preparation and plans, which accounted for psychosocial issues, but also because registration was inadequate and ascertaining that an individual or family required follow-up was difficult. When different authorities held responsibility for immediate follow-up and long-term follow-up, problems ensued. The objectives and purpose of each authority's involvement differed and, to some extent, each one held different views or mental models (Stout, Cannon-Bowers, Salas, & Milanovich, 1999) of what was needed, making good hand-over and collaboration difficult. In several countries, plans were underway to improve this situation based on difficulties experienced during previous disasters. For example, in Barcelona, a better care system had already evolved as a consequence of the Germanwings Flight 9525 crash in 2015. This plane departed from Barcelona en route to Düsseldorf, Germany. All 150 on board were killed, many hailing from Catalunya, Spain. Another problem arising in several cities was that

although contingency plans were available, they were not well known to the responders.

In many of the cities, it was hard to reach the affected populations with information regarding where support or crisis counselling could be obtained. This challenge was especially prevalent with children and young people. In Stockholm, a suggestion was made that complimentary information channels (e.g., websites) should be established to reach young people. Also, several participants pointed out that the family perspective was lacking and that divorced families and different family constellations were challenging.

In Barcelona, 200 trained volunteers were given basic training regarding individual reactions to help them screen those in need of follow-up. Employees in pharmacies were informed of referral possibilities and how to gently steer people toward follow-up resources. In Manchester, everyone who purchased tickets for the concert (i.e., the scene of the terrorist attack) were outreached to and invited to engage in an online well-being screening process. Such screening would repeat regularly for the first three years following the attack to monitor those affected. This process enabled those scoring within the clinical range to receive additional telephone triage calls and onward referral into evidence-based treatments close to where they lived. It also, however, exposed discrepancies in waiting times across the different regions of the UK.

Capacity building (i.e., increasing health professionals' knowledge about trauma and grief) took place in several cities. This consisted of presentations and videos on the web, in addition to reaching out to the general public through e-learning tools (Barcelona). This outreach was done through formal trainings and information meetings directly organised by the government as well as through sponsorship of trainings by professional organisations (Oslo). One issue that arose was that the stressing of "normal reactions" kept people from seeking help, leaving some struggling with traumatic reactions over time before realising they needed psychological support. In light of this issue, a stepped care approach seems to be necessary.

Lessons learned: Long-term response

The need for and content of a follow-up model in the long-term phase was stressed by several professional representatives. The discussion revolved around issues like responsibility, duration of follow-up, screening at different points in time, the needs of subgroups (children, adults, helpers, etc.), and professional versus peer support. The need for more research on which models to follow was highlighted. By collecting and sharing data on psychosocial responses across cities, for example by developing a systematic gathering of lessons learned in this field, more knowledge would be available to improve long-term follow-up.

In almost all cities, the professional representatives pointed out that they found the immediate response to be better that the long-term response. Structures were not in

place, and the different needs of survivors, the bereaved, witnesses, and helpers all contributed to problems in organising a long-term response.

Memorials and commemoration of the terror event differed across cities. Although people spontaneously found a shared place to lay flowers and mementos following the events, in some places these items had to be moved (e.g., moving the flowers on the Las Ramblas in Barcelona to a different location). A strategy for what to do with flowers, toys, drawings, etc. placed at the spontaneous memorial locales where the terror happens must be made in advance. There is also a need for people to visit or return to the scene, which requires coordination and organisation. In Manchester, an in-door filming of the site made a virtual visit to the scene possible for the victims, survivors, and bereaved. Following the Utøya killings, several papers were published about both the alleviation and the hardships that arose from visiting the site (Kristensen et al., 2017; Kristensen, Dyregrov, & Dyregrov, 2017).

Over time, the placement of more permanent memorials became conflictual in some locations, reflecting different opinions between and within the affected groups. Letting representatives of those directly affected be part of the process was a recommendation from several cities. The people living close to the suggested site for a memorial, like voluntary helpers at Utøya, protested the chosen site because they feared it would serve as a constant reminder. Others, bereaved and survivors, however, felt the selected place was where it had to be because it was close to where the event took place. Spending time and consulting with all parties involved is needed to reduce undue conflict. The process should also take into account that some spokespersons for those affected by terror might be very insistent and make consensus difficult to reach, without necessarily representing the entire group.

The same principles of consultation with the directly affected need to be applied for anniversary commemoration events. Such rituals constitute an important part of psychosocial care. They also offer an opportunity for social validation of the loss and suffering that took place. It is especially important to include those directly affected who were missed in the initial phase, such as the voluntary helpers or uninjured survivors.

The collaboration between private and public healthcare professionals has the potential for improvement. The use of different names, concepts, and terms within planning documents has caused problems not only between the private and the public sectors but also among different governmental/public agencies that operate with their own terminology. Shared mental models would facilitate collaboration and coordination in the long-term phase. While plans for immediate responses were usually in place, long-term follow-up was less well planned for. Proper long-term follow-up demands systematic registration (which was not always in place), screening for referral, and clear responsibilities among cooperating agencies. It also requires knowledge about each other's responsibility and competency areas. Without proactivity in these areas, those in need may go without proper intervention or treatment. Although the percentage of victims needing long-term follow-up may be

relatively low, the sheer number of people directly exposed to terror may make the actual number in need of follow-up very high (cf. 40,000 present in Nice). In the first year following the Manchester Arena Attack, more than 2,500 people were helped by the NHS psychosocial support service. Financial arrangements and healthcare systems that secure access to qualified services need to be set up to respond to such demands.

A combination of exposure factors (life-threat, duration of time in lockdown, viewing dead and mutilated bodies), social factors (social support available), and history (previous loss and/or trauma and previous psychiatric history) can be used to determine the need for follow-up. Several measures have been developed to screen people in disaster/terror situations (Brewin et. al., 2010). Because those directly affected come from different parts of a country or from foreign countries, they are spread over a large geographical area. Outreach efforts and proper follow-up are therefore difficult and have, unfortunately, failed in many instances. Systems, including collaboration with embassies, may have to be established in the event of future terrorist attacks. While in some countries (UK) families are assigned a caseworker, it is unclear how such assistance is secured with residents of other countries. Local reception centres could be one way of reaching affected populations when they return to their home countries, and online registration, information, and support might also be helpful in this respect.

One issue for long-term follow-up that arose was the collective fear spreading throughout the community, which was partly instigated by the intensive mass media coverage. Besides the clinical needs of those directly involved, it is a pressing issue to find ways to counteract such fear. This combatting of fear consists not only of providing accurate and early information to the public but also advising the public on how to resume normal activity, including making use of the spaces/places where the terror took place. Just assuming a “we are not afraid” stance is not enough to counteract self-imposed restrictions on movement and loss of personal safety and trust. It is important to work actively in making people feel safe and encouraging them to return to a more normal life. A special consideration is how to talk with children to reduce unnecessary worry in them (Dyregrov, Yule, & Raundalen, 2018). The advice given should be easily accessible and delivered to different target groups, taking into consideration their native language and digital literacy. Also, there is a need for governmental and collective efforts to avoid prejudice and hate crimes against political, religious, and ideological groups and to ensure tolerance, integration, and a sense of connectedness between communities.

Media coverage was an issue in all three phases dealt with. In the acute phase, some people stated that they felt “haunted” by the media. Efforts need to be made to protect victims and vulnerable people from this pressure. Over time, affected groups were given advice on limiting their exposure to the media coverage (Oslo, Nice, Manchester). For example, written guidelines were provided before the court case following the Oslo terror on both exposure to news media and interaction with the media.

The importance of caring for helpers was addressed by most cities' representatives. However, measures taken to achieve this aim varied. Following both the Nice and Oslo terror events, group debriefings were used to help personnel deal with and reflect on their work and roles. In both these places, psychologists and psychiatrists served as group leaders. Although the great majority of helpers cope well following such events, terror can involve extreme exposure to vivid impressions in the immediate phase. Adequate follow-up of helpers may help sustain their dedication and health over time.

Concluding remarks

This article presents the experience of professionals involved in organising and providing psychosocial support and representatives of the "users" of these support services. Even though the terrorist attacks were diverse across different cities, several common lessons were learned that can benefit the response following future terrorist attacks.

Leadership and chain of command must be as clearly defined in the psychosocial area as they are for emergency responders, with systems in place for early registration of affected people. Crisis contingency plans that include the psychosocial response should be regularly exercised to ascertain good psychosocial crisis management in the immediate, intermediate, and long-term phases.

Most terror events involve large numbers of people with a huge need for information, especially those desperately desiring information regarding their loved ones. Easily accessible, regular, updated, and verified information must be available for affected groups. Such information demands good coordination, cooperation, and exchange between different agencies.

The number of people and groups affected and the convergence of helpers put heavy demand on coordination within and between agencies. Systems must ensure good coordination, regulation, and use of human and material resources. While major affected groups are easy to identify, there can be several "hidden groups" (e.g., bystanders, spontaneous helpers, and people who were inadvertently in contact with terrorists) who also require that their psychosocial needs are met.

Systems must ensure good coordination, regulation, and use of human and material resources.

Peer support organisations can play an important role in the wake of a terrorist attack. Such organisations represent a resource that provides those in charge of psychosocial follow-up with an updated and realistic picture of people's needs. The government can play an important role in the formation and maintenance of such groups and organisations. It is

recommended that the long-term follow-up is planned for shortly after the terror event. That is because a recurring problem in follow-up has been the gap between early response and long-term follow-up.

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1. By peer support organisations, we mean organisations formed by those directly affected by the terror, such as survivors and bereaved family members. [↩]