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CASE REPORT

Case Report: Insights from The Champlain Towers Surfside Building Collapse on Prolonged Disaster Response and First Responders

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ABSTRACT

Prolonged disaster response scenarios present significant challenges to first responders yet remain underexamined with respect to resilience training and mental health interventions. The Champlain Towers collapse in Surfside, Florida, required extensive search and rescue efforts, involving collaboration between U.S. domestic and local teams and international first responders, representing the first time an international team contributed to search and rescue efforts on U.S. soil. Understanding the emotional and psychological impact of such operations is critical to improving first responder support systems. This paper offers a case study of the Surfside building collapse to illustrate the unique complexity of prolonged disaster response and, as such, inform best practice for both efficiency and wellbeing of first responders. This paper (1) reviews methods employed by first responders at Surfside aimed at offering emotional containment and fostering resilience, and (2) outlines methods for addressing gaps in the literature pertaining to how to best support first responders in the context of a prolonged call. The authors' current ongoing research aims to inform a more comprehensive and nuanced understanding of how to best support first responders in the context of a prolonged call to optimize the effectiveness of their response during the relief efforts and support their wellbeing in the aftermath. This ongoing research study aims to better understand how military-style resilience training and emotional support strategies, like those used by teams present at Surfside, may benefit civilian responders, and contribute to better disaster response frameworks.

Introduction

Disaster first responders operate under extreme stress and are routinely exposed to potentially traumatic events such as fires, earthquakes, mass-casualty accidents, and structural collapses. While many demonstrate resilience, a significant subset develops psychological symptoms or disorders in the aftermath of high-intensity operations, particularly when these involve prolonged exposure.[1-2] This paper focuses on such operations—*prolonged disasters*—defined as multi-day or multi-week response scenarios marked by sustained physical demands, emotional strain, and psychological complexity. Unlike acute events, which often resolve within hours, prolonged disasters require responders to be exposed to difficult scenes, and repeatedly confront traumatic stimuli, while coping with exhaustion, uncertainty, and cumulative loss.

The Champlain Towers South collapse in Surfside, Florida, represents a defining example of a prolonged disaster. On June 24, 2021, the 12-story condominium building collapsed, killing 98 people and devastating the surrounding community. Search and rescue operations began immediately, led by local emergency forces. However, the severity of the collapse quickly outstripped local resources. Within days, additional Federal Emergency Management Agency (FEMA)-coordinated domestic response teams hailing from all over the U.S. and, notably, a specialized Israeli Search and Rescue delegation from the Home Front Command (HFC), were simultaneously deployed—marking the first time in United States (U.S.) history that a foreign military unit participated in a domestic disaster operation. This highly advanced team has responded to numerous disasters such as in Mexico, Nepal, Haiti, Turkey and, most recently, Thailand. The structural complexity of the site, combined with environmental challenges such as extreme heat and the threat of a hurricane, extended the response over several weeks, intensifying the emotional and physical toll on those involved.[1]

The gravity of the situation is underscored by early data collected from Surfside. As introduced above, one study found that 53% of first responders met diagnostic criteria for at least one mental health disorder, including Post-Traumatic Stress Disorder (PTSD), major depression, or generalized anxiety, in the months following the event.[1] Rates were even higher among those directly involved in the recovery of human remains. This striking statistic highlights the psychological vulnerability of responders in the aftermath of Surfside—a prolonged disaster scenario. While the study does not directly compare prolonged versus acute responses, the elevated rates of PTSD, depression, and anxiety may suggest that sustained exposure and high-impact recovery tasks contribute to increased mental health risk. Future research comparing mental health outcomes in prolonged versus acute disaster contexts would help clarify whether extended deployments confer greater psychological risk.

Although existing literature on responder trauma is extensive, it has primarily focused on acute, high-impact events or retrospective studies such as those examining 9/11 or Hurricane Katrina.[3-4] There is relatively little research on how first responders cope emotionally during *prolonged deployments*, particularly while still actively engaged in the field. The Surfside case thus offers a rare opportunity to examine the psychological experiences of responders in real time and evaluate how different support strategies—especially those utilized by international teams—may inform future disaster response protocols. Surfside also represented the third highest death count in U.S. history, excluding terrorist attacks, offering an important opportunity to utilize it as a case.[1,5]

While models like Critical Incident Stress Management (CISM) and Critical Incident Stress Debriefing (CISD) are widely used and accepted as the gold-standard to address acute responder stress,[6-7] their efficacy—particularly in the context of prolonged disasters—remains understudied, and aspects of this intervention have been debated. Critics argue that these methods may have limited utility and may even be retraumatizing for certain individuals or prevent first responders from meaningfully operating during prolonged calls.[7] The Surfside operation offers a unique opportunity to explore this gap by reflecting on this event within the context of traditional U.S. practices and alternative approaches employed by the Israeli delegation.

Methods

This paper uses a descriptive retrospective case study approach to examine the toll of prolonged disaster response and assess emerging practices that may support responder well-being during

extended missions. It explores the emotional support practices used during the Champlain Towers South collapse, highlighting the varied approaches of U.S. and Israeli teams, with a particular focus on the daily psychological debriefing rituals implemented by the HFC delegation. Data were drawn from published accounts, institutional reports, and direct observation. Where applicable, select quotations are offered. By examining this international collaboration, we aim to better understand what practices may enhance resilience, reduce long-term psychological harm, and ultimately support first responders more effectively in the face of prolonged tragedy.

United States Team Data

Beidel's Critical Incident Response team, UCF Restores, was available to American rescuers who requested professional support in the context of the Surfside mission, and their subsequent research examined the psychological symptoms of first responders in the months after the collapse.[1,8] The researchers conducted anonymous monthly surveys of U.S. first responders using standardized measures to screen for symptoms of PTSD, depression, anxiety, suicidal ideation, and insomnia. Overall, average scores for the group did not indicate significant psychopathology in the immediate months post-collapse – supporting the notion of general resilience. However, when data were segmented, a stark difference emerged between responders who had directly participated in the recovery of human remains and those who had not. The subgroup involved in body recovery reported significantly higher symptoms across all measures. This study provided some of the first concrete data on how specific roles—like handling human remains—impact responder mental health.

As introduced earlier, over half (53%) of surveyed responders met provisional diagnostic criteria for at least one disorder in the months following Surfside. Within the subgroup of responders exposed to handling human remains, 15% screened positive for probable PTSD, 36.8% for depression, and 26.3% for generalized anxiety. By contrast, responders who did not handle remains showed much lower symptom levels on average. These results mirror patterns seen in other disasters, where exposure to grotesque or difficult scenes (e.g., handling human remains, bodies, or witnessing casualties) correlates with greater psychological distress. Beidel et al. conclude that not all first responders will develop emotional distress, but certain *recovery activities* can put some at higher risk, highlighting the need to identify, and provide targeted support for, individuals at increased risk.[1,8] These Surfside-related data reinforce the importance of monitoring responder mental health during and after operations, particularly for those in gruesome or demanding roles.

Existing practices for supporting responder mental health in disasters include immediate Psychological First Aid (PFA), peer/chaplain support, rest rotations, support dogs, and end-of-mission debrief/education sessions. These existing practices for U.S. first responders generally treat emotional support as a supplemental or elective aspect of operations – important, but often informal or only at specific checkpoints. There is no universal protocol that intentionally addresses first responder mental wellbeing or aims to mitigate the traumatic effects of the work. Crucially, the Beidel et al. study highlights that certain job roles and experiences during a disaster appear to heighten the risk of adverse mental health outcomes.[1,9] These results further highlight the importance of assessing and identifying techniques aimed at preventing or mitigating emotional distress within these domains. At Surfside, alongside the customary approach of the U.S. teams elucidated above, the HFC team utilized a more formalized daily protocol as part of their search and rescue (S&R) routine. Their team brought with them a set of embedded psychological practices shaped by military deployment experience. In the following section, we examine how the HFC team approached emotional containment and resilience during the prolonged Surfside mission—offering a complementary and instructive perspective on methods to bolster first responder resilience.

Techniques Used by the Home Front Command Team

The HFC delegation employed a structured, team-based approach to psychological support that was integrated into their daily operational rhythm as a key aspect of their rescue efforts. Examining it against the backdrop of the existing literature – which clearly calls for strategies to prevent/mitigate psychopathology in high-risk responders – is not intended as a comparison, but as a mechanism for

identifying key elements to integrate into current evidence-based disaster response guidelines.

The Israelis have a doctrine of attending to soldiers' mental well-being during deployments, shaped by experiences in past international disasters and military operations. In Surfside, their HFC team implemented a regimented daily debriefing ritual (detailed in the next section), which treated the emotional impact of the work as a matter-of-fact operational concern. The rationale is that continuously absorbing the sights, smells, and sorrow of the site without some acknowledgement could undermine individual first responder effectiveness and mental health. One team leader reflected, they were "*familiar with this emotional overload from previous delegations*" and made efforts to "metabolize the emotional and physical demands of the operation" in real time as an essential part of the operation.[10] This stood in contrast to the process of the domestic teams where, aside from brief "defusing" chats and the presence of mental health personnel at the periphery, a formal group processing was not part of the daily routine.

The HFC team's daily debriefing sessions at the end of every shift ensured that emotional check-ins were as routine as tactical briefings. In a quiet area near the disaster site, after each arduous day of work on the rubble pile, the team would gather. Importantly, this was not viewed as an unusual activity. Rather, it was treated as a routine and vital component of the mission, as much part of the fabric of disaster response as equipment checks or tactical briefings. The following are key features of the HFC daily debriefing protocol (**Table 1**).

Table 1. Core Features of the Home Front Command Debriefing Protocol

Element	Description
Frequency and Routine	Debriefings occurred daily at the end of the work shift, establishing a consistent ritual. This helped the team maintain a sense of normalcy and structure, and keep team members oriented to time and mission progress. The team also implemented a protocol mandating a 24-hour break from being on the pile after seven consecutive days of deployment.
Informal Group Setting	Sessions were intentionally held in a circle to promote equality and openness. This arrangement de-emphasized hierarchy and fostered a safe, mutually respectful environment. The atmosphere was relaxed, with seating for everyone and refreshments, to denote it as a space for decompression and support.
Normalization and Expectation	Debriefings were presented as a standard team activity, not therapy. This normalized discussing experiences and feelings, and destigmatized emotional expression.
Acknowledgment of Significant Experiences	Team members openly discussed and acknowledged the emotional and physical challenges of the mission, sharing their experiences and reflecting on how those experiences affected them. This allowed the team members to "metabolize" trauma in real-time and prevent its negative effects from accumulating. Both positive and negative significant moments were shared.
Leader-Led with Modeling of Openness	Mission commanders led and actively participated in debriefings, candidly sharing their own experiences. They set an example by sharing their experiences first, and modeled openness and vulnerability, demonstrating that these are acceptable even for leaders.
De-emphasis of Rank and Promotion of Cohesion	Rank was de-emphasized to foster team cohesion and psychological safety. All members had an equal voice, promoting trust, camaraderie, and mutual support. This egalitarian approach fostered a sense of trust and solidarity, bolstering resilience.
Post-mission debriefing	Both U.S. and Israeli teams had post-mission debriefing for long-term psychological health, bridging the gap between deployment and daily life. U.S. teams received psychoeducational briefings with information on post-trauma reactions and resources for support. At Surfside, U.S. first responder teams also received a psychoeducational debriefing at the time of demobilization focused on common post-trauma reactions and warning signs.

Note: This table summarizes the structured psychological debriefing process implemented by the Israeli Home Front Command (HFC) during their deployment at Surfside. Information is based on publicly available interviews, operational doctrine, and case-specific reporting.

Rationale for Home Front Command Method

The effectiveness of the HFC's integrated approach is grounded in years of programmatic development and has been refined through both combat and humanitarian operations. The rationale behind their methods offers insight into how responder mental health can be proactively supported before, during, and after deployment. The method also reflects a deep cultural value that first responders are also ordinary citizens and there is a responsibility to have people return to their lives after a mission in a state that is of sound body and mind. Surprisingly, there are limited explicit references within the global disaster response literature to preparatory processes prior to stress-inducing operations, or to interventions during and following such events. Thus, the Israeli method offers a valuable organizing framework to inform mechanisms for supporting and bolstering responders' resilience and overall mental wellbeing. In 2007, the Journal of Military Medicine published Psychological Guidelines for Team Debriefing based on Israeli strategies.[11] However, specific psychological processes have been implemented and refined within the army over the past several years to optimize mitigation of traumatic stress and its sequelae. At present the "MAGEN" ("Shield"), a resilience protocol developed by the Medical Corps, is utilized with commanders and soldiers and emphasized in field support.[12] The MAGEN protocol draws upon PFA, mobilization of coping resources, and offers support to fellow unit members. Used in both S&R efforts and combat operations, this protocol has allowed 80% of those who received in-field assistance to return to duty and has shown benefits reducing long term psychological distress.[11] It has also been adopted by the U.S. military ("iCOVER"). Preliminary findings examining this protocol in a U.S. sample showed a reduction in psychological distress symptoms during emergencies.[13]

The HFC bases their interventions on several guiding principles. The first is rooted in the classic – proximity, immediacy, and expectancy (PIE) – model for return to function.[14] The second principle involves training in individual and systemic crisis intervention skills. The rationale for this emanates from an internal study within the army on general self-efficacy having the capacity to influence professional outcomes in emergency situations.[15] The third guiding principle involves the provision of PFA/the MAGEN protocol by *commanders or peers* during stress-inducing events rather than designated mental health professionals that are peripheral to the core team.

On the systemic level, training focuses on working with commanders through preventive interventions, in-crisis response, and post-crisis follow-up, aimed at reducing distress secondary to emergency events. For example, during a mission there is constant internal evaluation and dialogue between team members. They are encouraged to avoid situations they feel they may be unable to handle. For example, as soon as a rescuer uncovers one end of a body, they pause to assess whether it may be too difficult for them. If so, that responder is sent to work elsewhere on the site and does not continue uncovering and recovering the body.

Specifically, within the HFC, several papers have been published about emergency interventions among first responders in civilian contexts. One such resilience-building program provides tools to commanders and the first responders they command for coping with burnout before, during, and after missions. It includes components such as providing knowledge for reducing anxiety, reinforcing meaning, setting a personal example, enhancing self-efficacy, and maintaining routine and structure.[16-18] First responders, as part of this military grade team, are also screened by the Medical Corps after a mission and monitored for PTSD symptoms to provide early intervention and support.

Lastly, this military delegation employed the use of a "Resource Conversation"—a structured conversation aimed at helping those who had been exposed to traumatic events, but had not yet completed a mission, to interface with them without inducing emotional flooding. The Resource Conversation is a structured dialogue with several aims, including: 1) preventing psychological distress and PTSD; 2) maintaining emotional and cognitive control and functional continuity; 3) enhancing personal resilience; 4) strengthening personal and unit cohesion; 5) reinforcing a sense of belonging; and 6) identifying non-normative stress responses and referring individuals for further care. The conversation includes cognitive elements such as expectations, facts, thoughts, emotional and physical awareness during the event; coping

components such as normalization, explanations about typical adaptation responses, and future planning; and components of social, familial, and unit support as validating environments. It is a strategy that is also utilized and implemented in real time.

The "Resource Conversation" allows for focused processing of the experience while avoiding emotional flooding in response to criticism of psychological debriefing methods.[19] While some support their clinical efficacy, others argue that they may be harmful due to the exposure of participants to graphic accounts of distressing events, potentially leading to secondary traumatization and emotional overload during active operations.[20] Accordingly, the Resource Conversation aims to limit overly emotional content. When emotions do arise, they are strategically acknowledged and reframed, with the facilitator redirecting the participant toward cognitive and functional aspects of the event.[21]

The HFC's comprehensive mental health emergency response model—known as the "complete response principle"— includes building and embedding resilience training during rescue and medical unit exercises, and is recommended for preparing units for transitions from routine to emergency, providing in-mission consultation for commanders, and facilitating post-mission mental closures.

Results

Findings from the Surfside response revealed distinct models of psychological support for first responders. The U.S. teams employed a primarily reactive, individual-based approach rooted in existing critical incident stress frameworks, while the Israeli team utilized a proactive, team-centered model that integrated daily debriefings and leadership modeling as standard operational practice. These methods reflect broader organizational and cultural differences in how responder well-being is addressed during prolonged disaster deployments.

While each team's practices reflect distinct organizational and cultural norms, a side-by-side view reveals distinctions in how psychological support was operationalized for each respective team (**Table 2**).

Table 2. Distinction in Emotional Support Practices at Surfside Between the U.S. and HFC

Aspect	U.S. Practice	HFC Practice
Emotional Debriefing	Optional, typically post-mission	Daily, structured, embedded during deployment
Leadership Role	Supportive; peripheral	Central; Commanders model openness and participate
Use of Rank	Maintained during operations and support efforts	De-emphasized during emotional processing
Peer Support	Present but informal	Centralized and trained as part of protocol
Timing of Support	Reactive or end-of-mission/post-mission	Proactive and integrated throughout deployment in addition to end/post
Cultural Framing	Emotional expression limited; possibly stigmatized	Expression normalized and institutionalized

Note: This table outlines key differences in how psychological support was structured, delivered, and normalized across U.S. domestic responders and the Israeli HFC delegation. Descriptions reflect observed practices, cultural framing, and responder-reported experiences.

As demonstrated in Table 2 above, a standard component of disaster response mental health support is the post-mission debriefing or demobilization briefing. These sessions, typically conducted when a team is about to leave the disaster site, are educational and preparatory in nature. The logic behind such briefings is rooted in research that trauma symptoms can be delayed – responders often cope "in the moment" only to find distress surfacing weeks or months later. Thus, providing education and resources is intended to encourage help-seeking and to mitigate long-term harm.[1,8]

Discussion

This paper has outlined two models of responder support during the Surfside collapse: the relatively less structured, checkpoint-based interventions used by U.S. teams, and the more structured,

team-wide protocol embedded into the Israeli delegation's daily operations. While each approach was shaped by distinct cultural and organizational contexts, their side-by-side deployment at Surfside allows for unique insights into the benefits and limitations of each. This discussion explores key themes emerging from those practices and their implications for future disaster response and reduced psychological strain and optimized resilience.

The U.S. model was primarily reactive, emphasizing individual access to behavioral health specialists, CISM teams, or other wellness personnel. While these supports were present and professionally administered, they relied largely on self-referral and personal initiative. Psychological support was available but not integrated into the daily rhythm of operations, leaving some responders without structured opportunities to process their emotional experiences in real time.

The HFC adopted a proactive, embedded model. Daily debriefings were mandatory, collective, and occurred at the end of each shift. These sessions were led by unit leaders who participated, modeling emotional openness and reducing the stigma often associated with discussing psychological stress. By incorporating emotional support into the operational structure, the HFC model made mental health care routine, expected, and accessible to all.

These differences reflect institutional and cultural norms regarding emotional expression and cultural framing in this context plays a critical role. In many first responder and military settings, emotional restraint is often valorized and help-seeking may be perceived as weakness, which may ultimately discourage support seeking or accessing resources that are available and promoted. The HFC structure allowed both junior and senior team members to share experiences without fear of judgment. This diminished the salience of the usual hierarchy during support sessions, and likely fostered increased psychological safety and cohesion. Viewing emotional responses as expected and manageable coupled with a team-oriented culture that encouraged shared responsibility for one another's well-being, reinforced the message that devoting attention to emotional wellbeing was an asset rather than a vulnerability.

The Surfside case and especially Beidel's[1] data illustrate the significant emotional toll prolonged disaster responses may have on first responders and highlights potential benefits of integrating structured mental health support directly into response missions. Surfside revealed gaps in U.S. practices, notably that first responders, despite their resilience, suffer deeply from traumatic exposure, intrusive memories, guilt, and emotional distress intensified by personal connections to the disaster.[1,9] An integrated approach aimed at fostering openness, reducing stigma, and reinforcing emotional well-being as a leadership priority, could contribute to increased overall well-being and resilience.

Translating the HFC approach broadly may present certain challenges; compulsory clinical group interventions immediately after trauma are debated in the literature, primarily due to the risk of retraumatizing responders. While not all aspects of the HFC approach may be directly transferable to domestic contexts, especially given differences in training and command culture, the underlying principles—daily emotional support, leadership modeling, and normalized vulnerability—offer valuable guidance. Training response leaders in PFA could further normalize mental health care, potentially enhancing current frameworks such as FEMA's Incident Command System.[22] From a policy standpoint, the Surfside experience highlights areas for growth within U.S. disaster response systems. Agencies such as FEMA, state Emergency Medical Services (EMS), and fire and police departments should consider adopting structured, peer-led debriefings as part of standard operating procedure during prolonged deployments. Rather than relying solely on optional/reactive supports, integrating emotional check-ins into the daily workflow may improve participation, normalize mental health care, and mitigate long-term psychological harm.

The collaboration between U.S. and Israeli teams at Surfside provided valuable cross-cultural learning opportunities. Each group contributed unique strengths—technical expertise from the U.S. and international experience and psychosocial support methods from Israel. Mutual flexibility, unity, and simple acts of listening created strong camaraderie and resilience, underscoring the value of open dialog and mutual disclosure among first

responders. This case study reflects the unique context of the Surfside collapse, and findings may not be fully generalizable without further research across diverse disaster scenarios.

Ultimately, resilience and recovery from trauma rely significantly on peer support, community acknowledgment, and collective remembrance, factors clearly demonstrated in the Surfside response. Such support, combined with structured, proactive mental health practices, could significantly mitigate psychological impacts for responders in future disaster operations. This collapse not only stands as a site of collective tragedy but can also be viewed as a catalyst for evolving how we protect the wellbeing of those who carry the responsibility of rescue, recovery, and public safety under the most dire and challenging of conditions.

Future Directions

Building on these case observations, our current research explores how such practices might be formalized or adapted across different disaster response systems. Specifically, we are investigating how to best support first responders emotionally in prolonged disaster scenarios, with a focus on cross-cultural nuances in emotional support mechanisms. The methodology employs a phenomenological qualitative approach to examine the lived experiences of first responders deployed to Surfside. Data is being collected through semi-structured interviews with members from both U.S. domestic and HFC teams. We expect that, to some degree, less formalized psychological support protects less effectively against greater emotional strain. A thematic approach to data anaysis will aim to identify cultural nuances in trauma processing, the potential role and value of peer support, and the need for some form of structured pre-, during, and post-mission support protocols. Integrating knowledge about the experience from the multiple teams present may inform practice guidelines to best support first responders in their work, especially given the limited data on outcomes for first responders operating in a prolonged disaster setting.

Improving Future Protocols: Drawing on the Surfside case and the current preliminary knowledge gleaned from this case, there are several recommendations that emerge for enhancing disaster responder psychological support **(Table 3)**.

Table 3. Recommended Enhancements for Prolonged Disaster Operations Based on Surfside

Recommendation	Description
Integrate Routine Emotional Check-ins	Whether modeled on the HFC daily debrief or adapted to local contexts, incident commanders should integrate regular (daily or shift-end) team check-ins during prolonged operations. These can be short (15-30 minutes) but should be a safe space for sharing experiences. Leadership participation is key to set the tone. Such practices should be codified in training, so they become as standard as safety briefings.
Emphasize Leadership Training in Mental Health	Ensure that those in command (fire chiefs, team leaders) receive training in recognizing stress injuries, facilitating peer support, and reducing stigma. Leaders should openly encourage help-seeking and be willing to model humanity to their teams. This top-down endorsement is critical in changing the culture of "toughness" to one of mutual care.
Deploy Embedded Mental Health Professionals	Having psychologists or counselors embedded with responder teams on-site as with UCF Restores (not just available by request or externally) can help implement supportive interventions. They can consult leaders on the fly, observe team dynamics, and gently engage with individuals or groups as needed. Their presence also normalizes the acknowledgment of mental wellbeing as inherently relevant and reinforces that it is a priority.
Cross-Train and Share Best Practices Internationally	Disaster response organizations worldwide should continue to share lessons learned. Workshops or joint exercises could include components on responder wellness. Learning from Israel's military-informed resilience techniques or from other countries' approaches (for instance, some countries use "psychological

Recommendation	Description
	decompression" periods after missions) can enhance domestic protocols. Likewise, U.S. innovations in peer support and trauma-informed care can benefit others.
Follow-Up Care	Just as important as on-site support is post-deployment follow-up. Agencies should have programs to check in with responders at intervals (1 month, 3 months, 6 months) after a major disaster, as was done by Beidel and colleagues. Those showing signs of distress should be guided to professional help. This ensures that concerns like PTSD or depression are addressed early and effectively.

Note: Suggested interventions are based on practices implemented as part of the Surfside response, with consideration of responder feedback, operational feasibility, and comparative international practices. Recommendations are intended for adaptation by agencies at various operational levels.

By addressing these areas, future disaster responses can be better equipped to protect the mental health of the responders who risk so much to save others. The hope, as expressed by these authors in an earlier piece, is that a better understanding of strategies like those used at Surfside will help future responders and therapists in responding to crises.[23] In essence, caring for the rescuer is not a secondary task – it is integral to the success and humanity of any disaster operation.

As agencies continue to reflect on lessons learned from Surfside, disaster response systems—such as FEMA and state-level EMS agencies—may want to consider examining the use of formalized peer-led psychological support into operational readiness practices. Specifically, incorporating structured, leader-modeled emotional debriefings as part of daily protocol during prolonged deployments could help destigmatize mental health care, enhance team cohesion, and reduce long-term psychological harm. Investing in such systemic practices is not only humane—it is operationally wise.

Conclusion

The collapse of the Champlain Towers South condo in Surfside was a tragedy that tested the limits of first responders' fortitude. The responders who answered the call faced a scene of unprecedented destruction and worked under unrelenting emotional (and environmental) pressure. This case study of Surfside's aftermath illuminates the profound emotional experiences of those responders – from the initial adrenaline-fueled push to save lives, to the later stages of heartbreak and exhaustion as they recovered victims day after day. It shines a light on critical gaps and opportunities in how we support the mental health of disaster personnel. Traditional practices have tended to treat responder emotional care as supplemental, but the Surfside experience – especially the Israeli team's daily debriefings – suggests that making emotional support a built-in, normalized part of operations can enhance resilience and team cohesion. The collaboration between domestic and international teams provided a unique learning environment, demonstrating that cross-cultural exchange can improve not only technical outcomes but also the psychological welfare of responders.

Despite differences amongst the teams who were present, the integrated response fostered a strong sense of camaraderie and mutual respect. All responders—American and Israeli alike—shared the experience of working tirelessly "as if they were looking for their own loved ones," as Miami-Dade's mayor remarked.[9] That common humanity helped dissolve differences. By the end of the operation, the foreign and domestic teams had become cohesive, united in purpose and in grief. Moving forward, disaster response protocols should evolve to incorporate these lessons: promoting open communication, training leaders to lead with humility and humanity, and ensuring that no responder goes through a prolonged crisis without adequate support. By doing so, we honor the service of first responders and uphold their well-being as they uphold the safety and hope of others. The Surfside tragedy will not soon be forgotten by those who were there – but neither should the lessons learned, which have the potential to improve how emergency services around the world prepare for and respond to the psychological impacts of disasters.

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