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The Interplay of Personal and Collective Resilience and Mental Health During Prolonged Conflict: Insights From Young Adults in Israel

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ABSTRACT

In this study we employed a repeated cross-sectional design to examine mental health among young adults in Israel using samples collected before and after the October 7th attacks and subsequent war, with a focus on resilience resources, coping strategies, and post-traumatic stress disorder (PTSD) symptoms. Additionally, we explored risk and protective factors associated with PTSD symptoms separately for each sample. Data were gathered from two online surveys conducted pre- and post-October 7th, encompassing 2131 young adults aged 18–24. Findings revealed a significantly higher rate of PTSD in the post-October 7th sample (43.3%) compared to the pre-October 7th sample (25.2%). In addition, the post-October 7th sample reported lower levels of resilience resources and social support, along with a greater reliance on emotional coping strategies. PTSD symptom severity was also significantly higher in the post-October 7th sample. Perceived threat emerged as a key risk factor, whereas social support and personal resilience acted as protective factors. Emotional coping strategies such as self-blame and avoidance were found to exacerbate PTSD symptoms. Post-attack predictors of PTSD symptoms included direct exposure to the injury or death of loved ones and internal displacement. These findings underscore the vital role of personal resilience and social support in mitigating the mental health effects of severe trauma. Furthermore, the study highlights the nuanced relationship between coping strategies and mental health, emphasising that commonly employed strategies may not always protect against severe stress. Identifying effective resources for recovery in the context of prolonged and intense threat is essential for informing intervention efforts.

1 | Introduction

The Israeli-Palestinian conflict, one of the world's longest disputes (Gelvin 2014), has inspired extensive research on the effects of armed conflict (e.g., Ayer et al. 2015; Canetti et al. 2013). Decades of violence have periodically intensified, most recently with the October 7th Hamas attack near the Israel-Gaza border, which caused over 1200 deaths, thousands of injuries, and more than 240 hostages (The Israel Institute for National Security Studies [INSS] 2023). Young adults were disproportionately affected, with 52% of the fatalities being under the age of 30 (Winreb 2024). Additionally, this age group includes individuals in the typical age range for both military conscription and reserve service in Israel, some of whom may have prior or ongoing exposure to military-related trauma and stressors (Levi et al. 2018; Mayer et al. 2024). The ongoing war, now (as of this

writing) over 14 months long, continues to exact a heavy toll (INSS 2023). Beyond physical tolls, mental health challenges have surged. Referrals to mental health services have increased sharply (Levi-Belz et al. 2024; Ministry of Health [MOH] 2023), and post-traumatic stress disorder (PTSD) rates among Israeli adults doubled following the October 7th attacks (Levi-Belz et al. 2024). Similarly, a study focused on Israeli young adults (ages 18–34) three months after the onset of the war revealed widespread adverse health and social consequences within this age group (Ben Simon and Konstantinov 2024), and a substantial rise in the rate of those dealing with severe and prolonged mental distress is expected in the coming years (Tishby 2024).

In the current study we examined the mental health impacts of the events of October 7th and the war among young adults in Israel aged 18-24, a demographic often classified as being in the stage of emerging adulthood. The existing literature consistently identifies young adults as a high-risk group for mental health issues (Arnett et al. 2014; Westberg et al. 2022). One reason for this finding is that emerging adulthood—a period characterised by the challenging processes of identity formation and life path selection (Arnett 2000, 2016)— is inherently a vulnerable phase (Davis et al. 2018). The recent events in Israel likely amplify these challenges, thereby increasing the risk of mental distress within this group.

1.1 | Exposure to Ongoing Conflicts and Post-Traumatic Stress Disorder

Communities in regions affected by geopolitical conflicts face significant emotional challenges (Goral et al. 2021; Pat-Horenczyk and Schiff 2019), including a persistent sense of instability and uncertainty that impairs daily functioning and coping abilities (Goral et al. 2021; Pat-Horenczyk and Schiff 2019). Consequently, individuals living in such regions—particularly children, adolescents, and young adults—are at high risk of developing PTSD (Hermesh et al. 2019; Dar and Deb 2022), a psychiatric disorder that can develop following exposure to traumatic event(s), either through direct personal experience, witnessing traumatic events, or learning about trauma affecting others, including through caregiving roles. PTSD is characterised by symptoms such as intrusive memories, hypervigilance, avoidance of trauma-related triggers, and feelings of helplessness and fear (American Psychiatric Association 2013), all of which can persist long after the initial exposure and severely impact daily functioning and quality of life (Goral et al. 2021; Solomon et al. 2017). Perceived threat has been identified as a key risk factor for PTSD in conflict settings, as individuals who appraise conflict-related events as highly threatening tend to exhibit elevated PTSD symptoms (Dokkedahl and Lahav 2024; Kurapov et al. 2024), as well as other adverse mental health outcomes (Goral et al. 2020).

1.2 | Theoretical Perspective

This study draws on two theoretical frameworks: Conservation of Resources (COR) Theory (Hobfoll 1989, 2001) and Resilience Theory (Bonanno, 2008). According to COR Theory, stress arises from the threat of resource loss, the actual loss of resources, or the failure to regain them. Resources are broadly defined as objects, conditions, personal characteristics, and energies that individuals seek to protect and accumulate (Hobfoll 1989). The theory proposes a vulnerability cycle wherein individuals with fewer resources are more susceptible to stress and subsequent resource depletion (Hobfoll 2001). The potential or actual loss of resources can be interpreted as a diminution of one's capacity to navigate challenges, consequently undermining mental health. Conversely, individuals with greater resource reserves are better equipped to withstand stress, buffer its psychological impact, and maintain mental well-being (Hobfoll et al. 2018; Hobfoll and Lilly 1993). In the context of this study, exposure to security threats, conflict-related events, and other stressful life experiences pose a risk to individuals' resources (and may lead to resource loss), but the presence of resilience resources can mitigate the adverse effects of these losses.

Resilience Theory conceptualises resilience as the capacity to sustain relatively stable psychological and physical functioning in the face of traumatic events. Resilient individuals may experience temporary disruptions but typically maintain a steady trajectory of psychological health and continue to engage in positive, meaningful activities (Bonanno, 2008). The literature highlights both personal and collective protective factors that act as protective factors that promote resilience. Namely, some of the individuals exposed to prolonged threat and conflict may adapt or habituate to stress, possibly due to the availability of personal and collective resilience resources (Braun-Lewensohn and Mosseri Rubin 2014; Braun-Lewensohn and Sagy 2014; Stein et al. 2018; Zelis and Shapira 2025).

1.3 | Personal Resilience

Personal resilience consists of skills, values, and qualities that protect individuals from the negative effects of crises, stress, and traumatic events, enabling them to adapt and adjust to change (Braun-Lewensohn et al. 2011; Masten et al. 2018; Zerach 2024). Such resilience includes the capacity to stay focused, think clearly, and manage unpleasant emotions (Connor et al. 2003). Personal resilience may buffer the relationship between exposure to traumatic events and the development of PTSD (Bennett et al. 2015; Cohen-Louck and Zvi 2022). For instance, Besser et al. (2015) found that individuals demonstrating high personal resilience reported lower levels of PTSD following exposure to trauma.

1.4 | Collective Resilience Resources

1.4.1 | Social Support

Social support plays a critical role in helping individuals manage and cope with life-threatening events (Bonanno., 2005; Masten 2004; Southwick et al. 2014). Previous studies have demonstrated that, for various groups of young individuals undergoing crises and distress, family and environmental

support are crucial for mental well-being (Achdut and Refaeli 2021; Refaeli and Achdut 2021; Refaeli et al. 2022; Vogel and Pfefferbaum 2014). For example, a study among young students living in conflict-affected areas revealed that support from family and friends influenced immediate emotional responses experienced during bombings, subsequently reducing the prevalence of anxiety disorders, major depressive disorder, and PTSD (Neria et al. 2010). In additional studies, various forms of social support have been found to buffer the relationship between exposure to threat and mental distress among adolescents and young adults (Dekel and Solomon 2016; Ozer et al. 2017; Shahar & Henrich, 2016).

1.4.2 | Community Resilience

Community resilience can be defined as the capacity of a community to withstand crises, maintain functionality, and adapt to post-disaster realities (Greene et al. 2018; Norris et al. 2008; Shapira et al. 2020). Individuals who perceive their community as strong and cohesive are better equipped to manage stress and adapt to adversity (Cohen et al. 2020; Shapira 2022). Research shows that communities in conflict-affected areas, such as southern Israel, often demonstrate higher resilience, and that this resilience is associated with lower mental health impacts (Leykin, Lahad, Cohen, Goldberg, & Aharonson-Daniel, 2013a, 2013b; Shapira et al. 2020). Similarly, studies from other contexts, such as hurricane-affected non-urban U.S. communities, have revealed that community support can mitigate the mental health impacts of disaster exposure (West et al. 2013).

1.5 | Coping Strategies

Coping strategies represent another protective resilience resource, as they help individuals overcome stress and adversity resulting from trauma and mobilise internal and external resources to effectively manage the aftermath (Lahad et al. 2017; Loo et al. 2016). People employing effective coping strategies are more likely to display resilience in the face of adversity and trauma. For example, a study of young people living in war zones found that using effective emotional and cognitive coping strategies helped mitigate the traumatic effects (Albala and Shapira 2023). However, not all coping strategies are equally beneficial. Research suggests that some coping strategies, such as self-blame and venting, may be associated with increased psychological distress over time (Morstead and DeLongis 2025; Nielsen and Knardahl 2014). Consequently, while beneficial coping strategies can reduce the negative effects of stressful events (Braun-Lewensohn 2012), other coping mechanisms may exacerbate distress rather than alleviate it (Besser et al. 2015; Braun-Lewensohn et al. 2009; Nielsen and Knardahl 2014).

1.6 | The Current Study

In the current study we aimed to examine the levels of PTSD among young adults (18–24) pre- and post-October 7th and identify risk and protective factors in this regard. Specifically, our objectives were as follows.

1. To assess differences in the prevalence and severity of PTSD among young people aged 18–24 in Israel before and after the October 7th attacks.
2. To explore resilience resources and coping strategies employed by young people before and after the attacks.
3. To identify risk and protective factors associated with PTSD at each time point.

2 | Methods

2.1 | Study Design

A repeated cross-sectional design was employed in this study. Data were collected via two online surveys: The first wave was conducted between Oct 2021-May 2023 (pre-October 7th attack), and the second wave was conducted between January-March 2024 (three-to-five months following the attack). The pre-October 7th sample was collected as part of our ongoing research on resilience and distress among young adults with varying degrees of conflict exposure.

2.2 | Participants and Procedure

For the recruitment of young adults at both study time points, a detailed sponsored advertisement was created outlining the research objectives and the specific target population for each group. The advertisement for the post-October 7th survey explicitly stated that the study aimed to examine the challenges, coping strategies, and resilience of young people following the events of October 7th and the subsequent war. The sponsored advertisement was distributed on social media platforms such as Facebook and Instagram, specifically targeting individuals aged 18–24, as these platforms are widely used by young people globally (Auxier and Andersen 2021 Andersen, 2021) as well as in Israel (Israel Internet Association, n.d.). While recruitment primarily relied on social media, efforts were made to maximise diversity within the sample by promoting advertisements across various regions in Israel to reach young adults from different geographic and socioeconomic backgrounds. The advertisement included a unique link and a QR code, providing participants with convenient access to the anonymous survey. The survey was conducted in Hebrew using Qualtrics software. Interested participants were first directed to a digital consent form, which they needed to complete before gaining access to the questionnaire, which took an average of 22 min to complete in the pre-October 7th sample and 23 min in the post-October 7th sample. Participants who failed to complete the primary outcome measure (PTSD scale) were excluded from the study. The final sample consisted of 2131 young adults aged 18–24, divided into two groups: Group 1 (n = 1216) representing the pre-October 7th group, and Group 2 (n = 915) representing the post-October 7th group.

2.3 | Measurements

Post-traumatic stress symptoms were measured using the 20-item PTSD Checklist for DSM-5 (PCL-5) (Weathers et al. 2021), which assesses symptoms over the past month. We used the validated Hebrew version of the PCL-5, published by the Israeli Ministry of Health, which instructs respondents to rate symptoms without reference to a specific index trauma (Palgi 2019). Scores range from 0 to 80, with higher scores indicating more severe symptoms. Consistent with DSM-5 criteria, participants were classified as meeting the threshold for probable PTSD if they endorsed at least one intrusion symptom, one avoidance symptom, two negative alterations in cognition and mood, and two arousal symptoms, each rated as 'moderate' or higher. The DSM-5 algorithmic approach is a validated and widely used method that closely mirrors clinical diagnostic procedures (Blevins et al. 2015; Shapira et al. 2020; Weathers et al. 2021). In a study by Hamama-Raz et al. (2021), the Cronbach's alpha for this tool was high ($\alpha = 0.93$). In the current study, reliability was $\alpha = 0.91$ for the pre-October 7th group and $\alpha = 0.88$ for the post-October 7th group.

2.3.1 | Exposure to Conflict-Related Events and Other Stressful Life Events

Perceived threat was assessed using a four-item scale adapted from Braun-Lewensohn et al. (2009). This measure captures subjective perceptions of risk associated with conflict-related events (e.g., rocket fire) over the past year. Respondents evaluate the perceived level of threat to themselves, their family, friends, and community. Each item was rated on a five-point scale ranging from 1 (*not at all*) to 5 (*very severe danger*), with higher scores reflecting greater perceived threat. In the current study, reliability was high, with Cronbach's alpha of $\alpha = 0.91$ for the pre-October 7th group and $\alpha = 0.83$ for the post-October 7th group.

The experience of non-conflict-related stressful life events was assessed using a single item. Participants indicated whether they had experienced one or more such events in the past 12 months (e.g., the death of a loved one, job loss) by responding on a dichotomous yes/no scale.

Consequences of the war were assessed using three items introduced only in the second wave of the study (post-October 7th) to capture war-related experiences. Participants were asked (1) whether someone close to them (e.g., a family member or friend): had been directly injured in the war; (2) whether they had experienced the death of someone close to them directly due to the war; and (3) whether they had been internally displaced as a result of the war. Each item was measured on a dichotomous yes/no scale.

2.3.2 | Resilience Resources

Personal resilience was measured using the 10-item Connor-Davidson Resilience Scale with responses ranging from 0 (*not true at all*) to 4 (*true nearly all the time*) (Connor and Davidson 2003). The score was calculated as the sum of all 10 items. In the original questionnaire, the Cronbach's alpha was $\alpha = 0.89$. In the current study, reliability was $\alpha = 0.87$ and $\alpha = 0.86$ among the pre- and post-October 7th groups, correspondingly.

Social support was measured using the 12-item Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al. 1988), assessing support from family, friends, and significant others. Responses ranged from 1 (*very strongly disagree*) to 7 (*very strongly agree*). Cronbach's alpha index for the original tool is $\alpha = 0.88$ (Zimet et al. 1988). In the current study, overall reliability was $\alpha = 0.92$ and $\alpha = 0.93$, for the pre- and post-October 7th groups, correspondingly. Subscale reliability was also high. For the pre-October 7th group, Cronbach's alpha values were $\alpha = 0.88$ for support from significant others, $\alpha = 0.91$ for support from family, and $\alpha = 0.92$ for support from friends. For the post-October 7th group, reliability coefficients were $\alpha = 0.89$ for support from significant others, $\alpha = 0.92$ for support from family, and $\alpha = 0.94$ for support from friends.

Community resilience was measured using the Conjoint Community Resiliency Assessment Measure (CCRAM-10) (Leykin et al. 2013a, 2013b), a validated tool for assessing perceived components of community resilience. The abbreviated version of the scale contains 10 items rated on a 5-point Likert scale, where 1 indicates *strongly disagree* and 5 indicates *strongly agree*. In a study by Shapira et al. (2020), this tool demonstrated a reliability of $\alpha = 0.85$. In the current study, the CCRAM-10 reliability was $\alpha = 0.91$ and $\alpha = 0.87$ for the pre- and post-October 7th groups, correspondingly.

Coping strategies were measured using the Adolescent Coping Scale (Frydenberg and Lewis 1993), which includes 18 different adaptive and ineffective coping strategies. Participants were asked about the frequency of use for each strategy, with responses ranging from 1 (*not at all*) to 5 (*very much*). An exploratory factor analysis identified two main groups of coping strategies: behavioural coping strategies (e.g., exercising and spending more time with friends) and emotional coping strategies (e.g., self-blame and avoidance). In the current study, the reliability for behavioural coping strategies was $\alpha = 0.76$ for the pre-October 7th group and $\alpha = 0.68$ for the post-October 7th group. For emotional coping strategies, the reliability was $\alpha = 0.70$ and $\alpha = 0.57$, for the pre- and post-October 7th groups, correspondingly.

Demographic information. Participants provided details about age, gender, religious status, perceived health and disability status, and perceived economic status. Additionally, participants were asked to indicate whether they had received any type of *emotional therapy/aid*.

2.4 | Data Analysis

Data were analysed by SPSS version 28. First, we produced descriptive statistics for the demographic characteristics and the main study variables. We compared the data for the samples before and after October 7th by chi-square tests for the

categorical variables and independent *t*-tests for the continuous variables. We also present effect size by Cohen's d for differences in the main study variables. Two hierarchical multiple regressions were conducted to examine the predictors of PTSD in the pre- and post-October 7th groups. The multivariate model for the pre-October 7th group was built in four steps: step 1 included demographic factors (sex, age, religiosity, and disability); step 2 included threat and stressful life events; step 3 included personal and collective resilience resources (personal resilience, social support, and community resilience); step 4 included two coping strategies: behavioural and emotional. The multivariate model for the post-October 7th group also included a fifth step with variables related to personal impacts during October 7th and the subsequent war.

2.5 | Ethics

Ethical approval for this study and for the final version of the questionnaire was granted by the ethics review board of the Spitzer Department of Social Work at Ben-Gurion University of the Negev (Approval no. OG31012024).

3 | Results

3.1 | Differences in Sociodemographic Characteristics Between the Pre- and Post-October 7th Samples

Table 1 presents the comparison of the sociodemographic characteristics between the pre- and post-October 7th samples. We used chi-square and independent *t*-tests to compare between the two samples in categorical and continuous variables, respectively. Significant differences were found between the two samples in terms of religiosity, disability, and therapy status. Those who defined themselves as 'secular' were 56.2% in the pre-October 7th sample and 62.5% in the post-October 7th sample; those who defined themselves as 'traditional' were 27.0% in the pre-October 7th sample and 15.6% in the post-October 7th sample; those who defined themselves as 'religious' were 14.1% in the pre-October 7th sample and 20.3% in the post-October 7th sample; those who defined themselves as 'ultra-Orthodox' were 2.7% in the pre-October 7th sample and 1.7% in the post-October 7th sample, $X^2(3) = 46.55$, $p < 0.001$.

The number of participants reporting a disability was significantly higher in the post-October 7th sample than in the pre-October 7th sample (14.9% vs. 21.6%, respectively); $X^2(1) = 16.30$, $p < 0.001$. Likewise, there was a significantly higher rate of therapy participation in the post-October 7th sample, (13.8% vs. 22.2%, respectively); $X^2(1) = 25.70$, $p < 0.001$.

3.2 | Prevalence of PTSD Among Study Participants Pre- and Post-October 7th Attacks

The prevalence of PTSD among young people was assessed as a dichotomous variable in accordance with the DSM-5 diagnostic guidelines (American Psychiatric Association 2013). In the pre-October 7th group, 25.2% of participants ($n = 306$) out of 1216 met the criteria for PTSD, compared to 43.3% ($n = 396$) out of 915 among the post-October 7th group. This difference was statistically significant, as indicated by a Pearson chi-square test ($\chi 2 = 77.555$, $p < 0.001$). PTSD severity was also analysed as a continuous variable using the PCL-5 sum score (range: 0–80), which changed significantly from 22.56 (SD = 16.36) in the pre-October 7th group to 30.17 (SD = 15.91) in the post-October 7th group, $t(2129) = 10.75$, $p < 0.001$, $d = 0.39$.

TABLE 1 | Comparison of the sociodemographic characteristics between the pre- and post- October 7th samples.

Variable	Pre-October 7th N (%)	Post-October 7th N (%)	X^2/t	*p*
Sex (female)	807 (67.6%)	648 (71.4%)	3.50	0.063
Age (M, SD)	20.8 (1.85)	20.8 (1.76)	−0.00	0.998
Religiosity			46.55	< 0.001
Secular	673 (56.2%)	539 (62.5%)		
Traditional	323 (27.0%)	137 (15.6%)		
Religious	169 (14.1%)	178 (20.3%)		
Ultra-Orthodox	32 (2.7%)	15 (1.7%)		
Disability (yes)	181 (14.9%)	198 (21.6%)	16.30	< 0.001
Therapy (yes)	165 (13.8%)	203 (22.2%)	25.70	< 0.001
Economic status			5.95	0.114
Financially strained	9 (0.7%)	16 (1.7%)		
Moderate means	106 (8.7%)	89 (9.7%)		
Comfortable	595 (49.0%)	453 (49.5%)		
Affluent	505 (41.6%)	357 (39.0%)		

Note: $n = 2131$; $n = 1216$ for the pre-October 7th sample and $n = 915$ for the post-October 7th sample.

3.3 | Differences Between the Samples in the Study Variables

Independent samples *t*-tests were conducted to compare various psychological and social variables in the pre- and post-October 7th samples (see Table 2).

Significant differences were observed in personal resilience, with lower scores in the post-October 7th sample ($M = 24.86$, SD = 7.19) compared to the pre-October 7th sample ($M = 26.02$, SD = 7.11), $t(2127) = 3.72$, $p < 0.001$, $d = 0.16$. Family support was also significantly lower in the post-October 7th sample ($M = 20.38$, SD = 6.43) compared to the pre-October 7th sample ($M = 22.49$, SD = 5.67), $t(2127) = 8.00$, $p < 0.001$, $d = 0.35$. Additionally, friend support was significantly lower in the post-October 7th sample ($M = 21.65$, SD = 6.18) than in the pre-October 7th ($M = 22.49$, SD = 5.50), $t(2127) = 3.31$, $p < 0.001$, $d = 0.14$. Others' support also showed a significant difference, with scores of ($M = 22.61$, SD = 5.43) in the post-October 7th sample and 23.88 (SD = 4.77) in the pre-October 7th sample, $t(2128) = 5.75$, $p < 0.001$, $d = 0.25$. Overall, social support was significantly lower in the post-October 7th sample ($M = 64.60$, SD = 15.29) compared to the pre-October 7th sample ($M = 68.87$, SD = 13.38), $t(2128) = 6.85$, $p < 0.001$, $d = 0.30$.

Emotional coping was significantly higher in the post-October 7th sample ($M = 2.52$, SD = 0.59) compared to the pre-October 7th sample ($M = 2.31$, SD = 0.67), $t(1979) = 7.22$, $p < 0.001$, $d = 0.47$. No significant differences were found in perceived threat, community resilience, or behavioural coping between the two samples.

3.4 | Multivariate Regressions Predicting PTSD

Two hierarchical multiple regression models were conducted to examine the predictors of PTSD in the pre- and post-October 7th samples. The first model (before October 7th) was built in four steps, with significant predictors and their relationships with PTSD interpreted below.

3.4.1 | Multivariate Regression for the Pre-October 7th Sample

In Step 1, both sex (female; $\beta = 0.17$, $p < 0.01$) and age ($\beta = -0.13$, $p < 0.01$) were significant predictors of PTSD, explaining 5.9% of the variance, $F(4,683) = 10.78$, $p < 0.01$. Being female was positively associated with PTSD. Younger age was also associated with elevated PTSD symptoms.

In Step 2, the model showed additional significant predictors, with perceived threat ($\beta = 0.31$, $p < 0.01$) and stressful life events ($\beta = 0.11$, $p < 0.01$) as significant contributors. This step explained an additional 11.0% of the variance, $F(2,681) = 45.07$, $p < 0.01$. Hence, threat perception showed a strong positive association with PTSD, implying that individuals who felt more threatened reported higher PTSD symptoms. Stressful life events also positively contributed to PTSD, though with a smaller effect.

In Step 3, personal resilience ($\beta = -0.26$, $p < 0.01$) emerged as a significant negative predictor of PTSD. Higher personal resilience was negatively associated with PTSD, indicating that individuals with greater resilience reported lower PTSD symptoms. This step explained an additional 12.9% of the variance, $F(3, 678) = 41.37$, $p < 0.01$.

Finally, in Step 4, emotional coping ($\beta = 0.38$, $p < 0.01$) was a significant positive predictor, and age ($\beta = -0.09$, $p < 0.01$), religiosity ($\beta = -0.09$, $p < 0.01$), threat ($\beta = 0.27$, $p < 0.01$), and personal resilience ($\beta = -0.15$, $p < 0.01$) remained significant. Emotional coping was positively associated with PTSD, suggesting that reliance on emotional coping strategies increased PTSD symptoms. This final model explained an additional 12.2% of the variance, and the four-step model explained 41% of the total variance, $F(2,676) = 70.93$, $p < 0.01$ (see Table 3).

3.4.2 | Multivariate Regression for the Post-October 7th Sample

The second model (after October 7th) was built in five steps, the first four mirroring those from the first model, and the fifth step

TABLE 2 | Differences between the samples in the study variables.

Variable	Pre-October 7th *M* (SD)	Post-October 7th *M* (SD)	*t*	*p*	Cohen's d
Threat	14.37 (3.64)	14.54 (3.71)	1.01	0.155	−0.04
Personal resilience	26.02 (7.11)	24.86 (7.19)	3.72	< 0.001	0.16
Community resilience	3.43 (0.91)	3.37 (0.88)	1.64	0.051	0.07
Family support	22.49 (5.67)	20.38 (6.43)	8.00	< 0.001	0.35
Friend support	22.49 (5.50)	21.65 (6.18)	3.31	< 0.001	0.14
Others' support	23.88 (4.77)	22.61 (5.43)	5.75	< 0.001	0.25
Social support	68.87 (13.38)	64.60 (15.29)	6.85	< 0.001	0.30
Behavioural coping	3.10 (0.71)	3.11 (0.64)	0.01	0.50	0.01
Emotional coping	2.31 (0.67)	2.52 (0.59)	7.22	< 0.001	0.47
	N (%)	N (%)	X^2		
Stressful life events	266 (33.8%)	287 (31.5%)	1.05	0.325	—

TABLE 3 | Standardized coefficients (β) for the pre- and post-October 7th samples predicting PTSD.

	Pre-October 7th sample				Post-October 7th sample				
	(Step 1)	(Step 2)	(Step 3)	(Step 4)	(Step 1)	(Step 2)	(Step 3)	(Step 4)	(Step 5)
Sex (female)	0.17**	0.12**	0.07	0.03	0.30**	0.24**	0.14**	0.07	0.08
Age	−0.13**	−0.13**	−0.12**	−0.09**	0.02	−0.02	−0.02	−0.02	−0.02
Religiosity	−0.06	−0.07	−0.08	−0.09**	0.03	0.00	−0.04	−0.02	−0.01
Disability	0.08	0.06	0.04	0.04	0.05	0.03	0.02	0.02	0.01
Threat	—	0.31**	0.31**	0.27**	—	0.28**	0.30**	0.23**	0.19**
Stressful life events	—	0.11**	0.09	0.09	—	0.10**	0.06	0.03	0.02
Personal resilience	—	—	−0.26**	−0.15**	—	—	−0.31**	−0.20	−0.22**
Community resilience	—	—	−0.03	−0.01	—	—	−0.01	−0.02	−0.03
Social support	—	—	−0.18**	−0.11	—	—	−0.19**	−0.11**	−0.12**
Behavioural coping	—	—	—	−0.04	—	—	—	0.03	0.03
Emotional coping	—	—	—	0.38**	—	—	—	0.44**	0.41**
Someone close to me was hurt	—	—	—	—	—	—	—	—	0.09**
I Experienced the death of someone close to me	—	—	—	—	—	—	—	—	0.07**
Internally displaced	—	—	—	—	—	—	—	—	0.06*
ΔR^2	5.9%	11.0%	12.9%	12.2%	9.3%	8.5%	15.3%	14.8%	2.3%
F	10.78**	45.07**	41.37**	70.93**	19.94	39.95**	58.71**	108.61**	11.50**

*$p < 0.05$.
**$p < 0.01$.

incorporating personal impacts related to the October 7th attacks and subsequent war (Table 3). Results showed that in Step 1, sex (female; $\beta = 0.30$, $p < 0.01$) significantly predicted PTSD, explaining 9.3% of the variance, $F(4,774) = 19.94$, $p < 0.01$. This positive association suggests that women in the sample reported higher PTSD symptoms than did men.

In Step 2, the addition of threat perception ($\beta = 0.28$, $p < 0.01$) and stressful life events ($\beta = 0.10$, $p < 0.01$) improved the model's explanatory power, adding 8.5% more variance explained, $F(2,772) = 39.95$, $p < 0.01$. Threat perception was positively associated with PTSD, indicating that those who perceived higher levels of threat reported elevated PTSD symptoms. Stressful life events also contributed positively, although with a smaller effect size.

In Step 3, personal resilience ($\beta = -0.31$, $p < 0.01$) and social support ($\beta = -0.19$, $p < 0.01$) emerged as significant predictors, adding 15.3% to the explained variance, $F(3,769) = 58.71$, $p < 0.01$. Higher personal resilience was negatively associated with PTSD, suggesting that resilient individuals reported lower PTSD symptoms. Social support also negatively contributed, implying that those with stronger perceived social support networks experienced fewer PTSD symptoms.

In Step 4, emotional coping ($\beta = 0.44$, $p < 0.01$) was a significant positive predictor of PTSD. The positive association with emotional coping indicates that individuals relying on emotional coping strategies reported higher PTSD symptoms. This model explained an additional 14.8% of the variance, $F(2,767) = 108.61$, $p < 0.01$.

In Step 5, three additional variables were introduced: knowing someone who was hurt ($\beta = 0.09$, $p < 0.01$), knowing someone who died ($\beta = 0.07$, $p < 0.01$), and being internally displaced ($\beta = 0.06$, $p < 0.05$). These predictors contributed an additional 2.3% to the model, $F(3,764) = 11.50$, $p < 0.01$. Each of these factors was positively associated with PTSD, suggesting that individuals with close connections to those who had been hurt or died, or those who were internally displaced, experienced elevated PTSD symptoms. In this step, the contribution of threat perception ($\beta = 0.19$, $p < 0.01$), personal resilience ($\beta = 0.22$, $p < 0.01$), social support ($\beta = 0.12$, $p < 0.01$), and emotional coping ($\beta = 0.41$, $p < 0.01$) remained significant. The total model explained 50.2% of the variance in PTSD symptoms in the post-October 7th group (see Table 3).

4 | Discussion

In this study we investigated differences in PTSD prevalence and severity, resilience resources, and coping strategies among young people aged 18–24 in Israel, focussing on their associations by comparing two independent samples collected before and after the October 7th terrorist attacks and subsequent war. The findings reveal the profound mental health toll of the current war, reflected in higher PTSD prevalence, lower resilience resources and social support, and greater reliance on emotional coping strategies. By identifying key risk and protective factors, the study sheds light on potential mechanisms that shape mental health outcomes in the context of collective trauma. The following discussion situates the findings within the broader discourse on resilience and coping theories, emphasising their

theoretical contributions and practical implications for promoting the mental health and well-being of young people in conflict zones.

The prevalence of PTSD was significantly higher following the October 7th, 2023 attacks—the event that marked the onset of the current war – with close to half of the participants found to be in the diagnosable range for PTSD and a concurrent general difference in symptom severity. These figures align with literature on trauma exposure in both man-made (Charlson et al. 2019) and natural disasters (Beaglehole et al. 2018), where abrupt and large-scale traumatic events are often linked to significant mental health burdens both in the general population, and particularly among young adults (Dar and Deb 2022; Myles et al. 2018; Parslow et al. 2006). Moreover, these results are consistent with preliminary evidence from Israel identifying young adults as especially vulnerable in the context of the current Israel-Hamas war (Shrira and Palgi 2024). Whereas Shrira and Palgi's research was conducted during the first week of the war, our study, conducted three-six months after its onset, highlights that the high mental health toll among young adults is not only acute but also persistent over time.

The observed lower levels of personal resilience and social support may reflect the destabilising effect of collective stressors on both individual and community-level support mechanisms. Notably, the greater reliance on emotional coping strategies post-October 7th suggests that participants in this group were more likely to internalise their distress, potentially exacerbating their vulnerability to mental health consequences. Within theoretical frameworks of stress and coping, resilience may be conceptualised as a dynamic process wherein individuals, when confronted with adversity, utilise both internal and external coping resources, aiding in the recovery from traumatic experiences (Métais et al. 2022). Our findings align with what is commonly known as the 'erosion model,' suggesting an association between ongoing adversity and lower levels of these resources (Schwarzer 2024). It is important to note that in the context of the Israeli-Palestinian prolonged conflict, prior evidence suggested that most individuals did not develop major mental health disorders as a result of exposure to conflict-related violence (Sagy and Braun-Lewensohn 2009; Shapira et al. 2020). Instead, affected populations, especially adolescents and young people, often employ a complex pattern of coping styles to navigate these adverse experiences (Albala and Shapira 2023). However, the current war has imposed exceptional physical, psychological, and social burdens on the population, challenging both personal and communal coping resources to an unprecedented extent. The lower levels of resources observed in this study may be partly explained by fatigue within individuals and social networks due to the prolonged duration of the conflict (Kaim et al. 2024).

Furthermore, some of the observed differences between the pre- and post-October 7th samples, particularly in religiosity, disability rates, and therapy use, may reflect broader societal and psychological shifts resulting from the war itself. While this study primarily focuses on mental health consequences, future research should explore how large-scale traumatic events shape sociocultural and health-related trends over time, including shifts in identity formation processes and healthcare utilization.

The findings from the multivariate models offer valuable insights into the factors contributing to PTSD among the pre- and post-October 7th groups. Perceived threat and reliance on emotional coping strategies consistently emerged as risk factors for PTSD in both models, whereas personal resilience served as a protective factor across both time points. These results align partially with Hobfoll's COR theory (Hobfoll 1989), which posits that resource loss under threat can exacerbate stress and psychological harm. In this study, perceived threat was strongly associated with PTSD symptoms, consistent with the theory. Furthermore, as mentioned, COR theory suggests that retaining or gaining resources during periods of threat can safeguard other critical resources, including mental well-being (Hobfoll et al. 2018). Personal resilience, as identified in this study, exemplifies such a protective resource. However, the theory also emphasises the effort to acquire resources during stress as a key strategy for recovery (Hobfoll 1989). In contrast, our findings suggest that this effort may not always suffice to protect mental health, particularly when individuals rely on emotional coping strategies such as avoidance or self-blame, which in our study were linked to greater PTSD symptoms. Moreover, under severe and prolonged threats, such as those examined here, even more active behavioural coping strategies may prove insufficient.

Our findings extend COR Theory by examining its applicability in the context of prolonged conflict. While they support the theory's core premise—that retaining resources is critical during periods of threat—they also underscore that not all resources are equally effective in promoting mental health under prolonged conflict. Specifically, although prior research highlights the protective value of certain coping strategies (Albala and Shapira 2023; Braun-Lewensohn 2012), our results differentiate between emotional strategies, which are associated with increased PTSD risk, and behavioural strategies, which offer limited benefit in mitigating PTSD symptoms. This distinction aligns with Hobfoll and Lilly's (1993) proposition that 'resource loss is more powerful and more potent than resource gain' (p. 131). In the context of prolonged and ongoing threats, such as those currently experienced in Israel, even proactive coping efforts may be insufficient to counterbalance the cumulative effects of resource loss.

Moreover, the role of emotional strategies introduces a novel dimension to COR Theory. Our findings suggest that, under prolonged threat, emotional strategies aimed at resource gain may not only be ineffective but potentially harmful. Identifying which resources provide meaningful protection under extreme and prolonged stress is crucial for designing effective interventions. This effort is especially pertinent in light of resilience theory, which has linked some emotional strategies to positive outcomes even in the face of severe traumatic situations (Bonanno, 2008). Ultimately, prolonged exposure to threat demands a distinct set of resources and coping strategies. Furthermore, in the post-October 7th sample, additional factors gained significance, including direct personal impacts from the attacks and subsequent war as contributors to heightened PTSD risk. These results correspond with evidence from other conflict zones, such as the Russia-Ukraine War (Palace et al. 2024). These findings underscore the need for tailored interventions to address the unique challenges posed by extreme trauma and emphasise the importance of strengthening both individual and

collective resources to mitigate the mental health toll of collective trauma among young people. Interestingly, contrary to previous findings that highlight the role of community resilience in protecting mental health (Leykin et al. 2013a, 2013b; Shapira et al. 2020), in the current study we did not find such a contribution. This discrepancy may be due to the fact that during emerging adulthood, community support is less important to young adults, who tend to rely more on peer and family support, compared to older individuals. However, it is also possible that the nature of the October 7th attacks and the subsequent war—both of which represent large-scale collective traumatic events—may have disrupted typical community support mechanisms, limiting their protective role. In times of crisis, the effectiveness of community resilience may depend not only on its existence but also on how accessible and functional these resources are for affected individuals. Given that the healing process following these events is likely also to have a collective dimension, efforts should be made to strengthen and expand access to community-based resources for young adults.

4.1 | Implications for Practice and Policy

The findings highlight several key implications for practice and policy. First, mental health interventions should prioritise individuals at heightened risk, including younger individuals, and those with direct exposure to harm or displacement. Programs that strengthen resilience and rebuild social support networks are particularly crucial in the aftermath of large-scale trauma. Additionally, mental health services should incorporate strategies to address coping mechanisms, providing adaptive frameworks and skills for managing distress.

From a policy perspective, the findings underscore the urgent need for targeted policies to address the mental health challenges faced by young adults in the aftermath of collective trauma. Policymakers should prioritise the development and funding of accessible mental health services tailored to the unique needs of this population, including trauma-focused therapy.

A particularly important consideration in the Israeli context is the impact of mandatory military conscription and reserve service, which shape the experiences of many young adults during this period of life. Military service, especially during times of conflict, may expose individuals to combat-related trauma, operational stress, and prolonged uncertainty, all of which can exacerbate mental health challenges (Levi et al. 2018; Daphna-Tekoah and Harel 2023). Given that a significant portion of young adults in Israel serve in the military or other national service frameworks, mental health policies should integrate trauma-informed care and post-service support programs to address service-related distress and promote long-term well-being. Additionally, expanding mental health resources within the military—particularly through enhanced access to military mental health professionals and targeted interventions for active-duty and reserve personnel—could help mitigate the cumulative psychological burden of service-related exposure.

Additionally, policy-makers should consider the broader impact of trauma on young people's future perceptions, and aspirations, as many in this age group are yet to have a clear occupational path. Educational and vocational programs (e.g., higher education institutions) should integrate mental health support, mentorship, and career counselling to help young adults rebuild confidence, navigate uncertainty, and identify meaningful opportunities despite the ongoing challenges. Moreover, educational institutions and workplaces should incorporate mental health considerations, such as flexible schedules, mental health days, and awareness campaigns, to reduce stigma and encourage help-seeking behaviour.

4.2 | Limitations

This study has several limitations. First, the reliance on self-report scales for assessing study constructs may have introduced a response bias, as participants might have over- or under-reported symptoms or behaviours due to social desirability or subjective interpretation. Second, the repeated cross-sectional design limited the ability to draw causal inferences or track individual changes over time, as different cohorts were sampled at each time point. Future research would benefit from employing longitudinal designs to examine how mental health outcomes and resilience evolve over time within the same individuals. Third, although the study identifies key factors associated with PTSD, the cross-sectional nature of the data prevents conclusions about directional or temporal relationships between these variables. Additionally, the study does not capture the potential role of contextual variables, such as cultural factors, geographic differences in trauma exposure, or broader systemic influences that could shape coping mechanisms and mental health outcomes. Fourth, given that recruitment was conducted through social media and participation was voluntary, the study may be subject to self-selection bias. Individuals experiencing greater distress or higher levels of resilience may have been more or less likely to participate, potentially influencing the findings. Although social media recruitment enabled access to a broad and diverse sample of young adults, future studies should explore additional recruitment strategies to enhance representativeness. Finally, the focus on short-to medium-term impacts highlights the need for further investigation into the long-term consequences of the conflict, particularly as young adults navigate their future in a highly unstable environment.

5 | Conclusions

This study sheds light on the mental health impacts of the October 7th terrorist attacks and subsequent war on young adults in Israel, indicating higher PTSD rates, alongside lower levels of resilience resources and social support in the post-October 7th sample. The findings underscore the immense challenges faced by young adults in navigating collective trauma and emphasise the importance of understanding the dynamic associations between risk and protective factors in shaping mental health outcomes.

As young adults were, and continue to be, one of the most affected population groups in the current war, our findings underscore the critical need to advocate for their needs and implement dedicated policies and interventions to help them cope with the adverse consequences of the conflict. Further research is essential to understand the long-term trajectories of recovery and to develop effective strategies for addressing the mental health needs of populations exposed to collective trauma.

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Ethics Statement

This study was reviewed by the ethical committee of the Department of Social Work at Ben-Gurion University of the Negev (approval no. OG31012024). The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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