The Evolution of Therapists: Transitioning to Combat Supporters – Treating Victims of Terrorism

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Abstract

This article discusses the treatment of victims of terrorism, including witnesses, wounded individuals, and bereaved individuals. It acknowledges the existence of various affected populations, such as soldiers in combat, special units of the Israel Defense Force, and personnel involved in disaster victim identification. The article emphasizes the need for professionals like psychologists and social workers to play non-traditional roles in providing support and therapy to these victims. It addresses the stages of intervention, with a focus on immediate and post-exposure care for civilians and combatants. Key issues include the shared traumatic reality for therapists and patients, the complexities of post-trauma adaptation, and the specific demands on professionals treating individuals in risky situations. Additionally, it discusses the timing of treatment and how combatants and civilians respond to therapy during active combat.

Keywords: Terrorism, Israel, War, Trauma, Social Work, Iron Sword, IDF

Introduction

This article was written amidst the 'Iron Swords' war that engulfed the state of Israel. This was initiated by the Israel Defense Force (IDF) in response to a coordinated and brutal attack by HAMAS on October 7th, 2023, primarily targeting the southern regions of Israel, including civilian and military sites, Jewish settlements, and innocent citizens. HAMAS attack resulted in the tragic loss of over 1400 lives and the abduction of more than 240 children, women, men, and the elderly, presenting a profound challenge to the entire nation of Israel. The aim of this article is to discuss ways of treating victims of terrorism: witnesses, wounded, and bereaved. This includes injured non-uniform-wearing soldiers, soldiers exposed to terror in direct combat against the enemy, special units of the Israel Defense Force (IDF), ZAKA (Disaster Victim Identification Organization) personnel, and the Forensic Identification Department personnel dealing with the alarming consequences of terrorism. The existence of various affected populations, as mentioned above, necessitates professionals—psychologists, social workers, as well as parents and families in constant contact with the victims who are exposed to complex content — and therefore acknowledge and specialize in multiple roles that are not conventional for them. For instance, when therapists are required to support and provide therapeutic care for soldiers in the midst of combat.

This article will address the stages of intervention for victims of terrorism, emphasizing the attempt to provide tangible tools for therapist and professional personnel in immediate contact with victims, civilians, and soldiers in combat or war zones. The focus will be on those accompanying victims in the initial stages and, subsequently, post-exposure to a terrorist event. Additionally, there will be consideration for civilian and combat witnesses, officials, wounded, and individuals who experienced loss and bereavement. The individuals mentioned above are:

civilians, soldiers, ZAKA personnel, etc., in this article, will be referred to as witnesses and combatants due to their involvement in risky situations and combat.

Key issues to be discussed in the article will include witnessing terror event(s) and the shared traumatic reality for therapists and patients, the complexities of post-trauma adaptation in therapy, specific demands on professionals treating combatants and civilians under terrorist attack, and the appropriate timing for their treatment. Furthermore, the discussion will include how combatants and civilians respond within the treatment space, as well as addressing recovery time during active combat.

Witnessing Terror: Shared Trauma of Therapists and Patients

Before delving deeply into the aforementioned issues, it's important to remember that therapists, in particular, in the modern era where all information is exposed in the media, are themselves witnesses to the horrors that have occurred. They too are liable to suffer from trauma. This amplifies when their very role directs them to hear the difficult testimonies during the therapeutic process. One of the concepts I discussed in my previous research, "The Unseen Suffering of Terrorism - Miracle or Disaster" (Chouraqui-Elfassi, 2006), is 'terror witnessing'. Under this title, I included people who witnessed severe terrorist events but were not directly affected; people who witnessed events unfold or heard about these harsh events through the media. It is, of course, evident to acknowledge witnesses who were present during these severe incidents as they were exposed and affected in one way or another.

Given this perspective, I sought to highlight the importance of addressing a broader community which impacted by terror in which including therapists, who, in the modern era, watch horrifying scenes unfold from the comfort of their living rooms, for example such as during the collapse of

the Twin Towers when millions of people witnessed victims jumping out of windows to their deaths and other horrifying scenes. Thus, in this situation, the public becomes witnesses to terror (Nader, 2001).

As a result of the described situation, therapists find themselves in a situation where they need to be attentive to their patients yet simultaneously attempt to avoid potential fears that threaten them as well. The anxiety that pervades these situations can be so intense that it inhibits the therapist from engaging with their own emotions. This might adversely affect the therapy and prevent the patient from encountering the darkest chambers they need to face for healing (Herman, 1992). Additionally, besides the difficulty in facing the horror, therapists are fearful of overexposure and, therefore, potential breakdown, which might be caused to themselves or their patients simply by dealing with the horror (Cohen et al., 2014). Therefore, this could lead to empathetic failures on the part of the therapists, such as incomplete absences and attentiveness, or a conscious or unconscious attempt to move away from subjects that invoke anxiety and fear within the therapist. These failures might impact the treatment and commonly lead to a decrease in the therapists' self-worth (Somer et al., 2004; (2012, Tosone et al.).

Boulanger (Boulanger, G. 2013) illustrates symbolically how, after Hurricane Katrina in New Orleans, therapists and patients had to climb over the rubble of buildings to reach the clinic. This situation symbolized and emphasized the fact that the patient and the therapist both dealt with the very same complex reality. Boulanger highlights the difficulty for therapists in providing a safe space for processing severe experiences when they themselves are exposed to the same horror. Furthermore, he describes that due to the nature of their profession, the public's expectation for therapists to excel beyond their own capabilities and take care of others despite the challenges they face in their roles, creates a situation of extreme isolation for therapists.

Another challenge that arises in situations of shared trauma witnessing is the blurring of boundaries between therapist and patient. In cases of shared trauma, both parties face difficulty and exposure to fear. This, which is evident to the patient, does not often occur in ordinary times when the therapist can hide their personal pressures. As a result, the patient may, for instance, show more interest in the well-being of the therapist, and the therapist may, on their part, share thoughts or feelings that, under normal circumstances, they wouldn't share to keep the focus on the patient and prevent external influences on the treatment. This can sometimes lead to a negative diffusion between personal and professional lives (e.g., "I was also very afraid yesterday when the alarm went off"). On the other hand, such sharing of emotions by the therapist may significantly strengthen the patient and dispel their sense of loneliness, as argued by certain critical and feminist approaches to therapy today (Weiss, 2003). Therefore, it is crucial to reassess the appropriateness and the extent of sharing with a particular patient. An additional difficulty that therapists face in such situations is the need to be with their families and take care of them as well. This dilemma, the conflict between treating patients in need of assistance and the therapist's own family needs, can create a crisis in the therapist's life. This can contribute to a sense of entrapment, hindering therapists from engaging in their usual treatment practices with their patients (Baum, 2012).

'Under Fire' – Treating patients during combat

In my role as a specialized therapist aiding victims of terror, IDF soldiers, and their families, I've observed a clear distinction between two scenarios: the condition of war, involving conflict between Israel and foreign armies, and the state of terror incidents carried out by terrorists targeting random civilians. This discussion pertains to an intermediate situation, a

unique state of combat under a terror event, exemplified by the harsh and horrifying incidents that occurred in Gaza-border communities on October 7th (2023) events. In such events, soldiers and civilians grapple with a terror event characterized by a unique complexity—a combination of two aspects together: war and terror. Another distinctive feature of such a terror event is the actions carried out in the area by military and civilian units whose role is to handle the immediate consequences of terror. For example: searching for missing persons, collecting, and treating bodies, scanning the area, and collecting materials from the scene. A terror event with these characteristics demands tailored treatment and engagement from therapists and personnel involved in the treatment. Throughout the current war, I have had sessions with combatants engaged in various missions and families supporting their sons and daughters who are in the combat zone.

In my current role as a therapist during the 'Iron Swords' war I conversed with soldiers and civilians who were in the war zone in various ways. Some spoke to me amidst the destruction using stifled voices over the phone, while others left me voice messages, hoping I would listen and respond. In these messages, they mostly described horrific plastic descriptions or non-plastic stories but narrated difficult and painful events. For instance, scenes of an abandoned stroller, signs of cell phone drag marks on the dirt indicating a person being dragged, and exposure of fighters to highly intimate situations of people affected and during their daily lives (given that the terror event suddenly disrupts their lives). Such combat against an enemy while dealing with a terror event and its ramifications necessitates various forms of therapeutic approaches by the therapist different from ordinary times, which will be detailed in this article.

During our conversations, soldiers described their experiences even during their short breaks at home. One of the soldiers described how he found himself constantly organizing things

obsessively: dismantling the "sukkah" (temporary hut or shelter traditionally constructed for the Jewish holiday of Sukkot), mowing the lawn, cleaning the house so that if 'something' bad were to happen suddenly, everything would be in order and not as exposed, with a sense of shattered intimacy. The soldier further described how, as he stood observing his home and its pastoral scenery, the actual scene that unfolded before his eyes was drenched in blood and harsh sights. One of the difficult feelings that the witnessing soldiers shared was linked to a sharp dissonance between what is normal and what is not. In other words, the scenes of normal life— a half-drunk bottle, a TV program continuing in the background— all of these coexisted in a jumble with the 'abnormal': splashes of blood, broken items, and 'missing signs' of interrupted actions.

The soldiers in the field experienced an additional emotion upon encountering the distressing scenes: a feeling of betrayal and anger toward the government, sensing abandonment by the state. They described the expectation that they have from the state to lead a strong and tough response, which is believed to bring a little comfort and relief, addressing the inherent weaknesses and breakdown they experience. This phenomenon is also described in literature by Mazur, E. & Robine, N. G., 2013 and Clemente, S., 2022. This feeling of wanting to regain power and address the overwhelming feelings of helplessness is coupled with a deep commitment to continue the combat actions. This strong desire is tied to the hope of giving an "end" to the story. For example, it could mean finding answers for a family with a missing relative or locating terrorists in hide. Because of this, any departure from combat to rest, in many ways, could also present difficulties for them (Smith, M., Robinson, L., & Segal, J., 2023; Rotenberg, 1994).

Debriefing

In conversations with soldiers in active combat the field, many expressed a desire to share what they saw specifically with those exposed to the same or similar horrors they faced in the combat zone/terrorized territory. The reason behind this was that they felt that "outsiders wouldn't understand." Conversely, they described that in the field, there are people they called "shielding individuals" - soldiers who are not professionals attempting to provide some form of emotional support to the soldiers in the field. The soldiers mostly described that they did not feel safe confiding in the "shielding individuals" with what they were going through and did not trust them. In their own words, they describe they are "not going to take the risk of a breakdown when no one will be there to pick them up". They preferred to talk to professional therapists. Which means that there is a paradox created in the field during combat: on the one hand, they sought people who were there, but on the other hand, they only wanted professionals. What ultimately determined their preference was the desire for professionals who understand that a stranger won't comprehend this.

One of the most central tools in treatment is debriefing, often cited (Kinchin, D. 2007) as an effective tool in the context of trauma. The meaning of this concept is to engage in conversations with people who have experienced trauma, aimed at processing the difficult experience and alleviating it, in an attempt to reduce post-traumatic symptoms. There are various types of debriefing methods: individual, or group structured (CIPR), aiming to assist participants in creating a cognitive narrative, an opportunity for ventilation, and raising awareness of their coping mechanisms. The training and theories instruct treatment personnel in the principles of debriefing: the structure of the conversation, questions to ask, and more (Raphael, B. & Wilson, J. P., 2000). The prevailing belief among treatment personnel is that debriefing is the most basic

and perhaps most significant tool in therapeutic intervention, especially when dealing with exposure to trauma. This belief is based on the perception that the more one helps a survivor become aware of what they experienced physically and emotionally, the better they can contain the event and place it in a more 'organized' internal space. Therefore, the hope is that they can lead a more normal life. Just as among professionals, this perception is seen as the most appropriate way to assist survivors in the broader public, and the recommendation is often, "talk about it" (Mitchell, S. A., Block, M. G., & Berger, M., 2006). Professional literature raises a question: does debriefing help or harm people suffering from trauma? According to professional literature, it is found that in many situations, debriefing itself revives the traumatic situation and exacerbates the victim's distress (Hochberg, 1986, 2009; Perry, P., 2014; Cyrulink, B., 2018). In such a situation of reviving the traumatic event, the actual event may not take place, but all the emotions that enveloped the person during the trauma are very real, creating a kind of additional traumatic condition. Therefore, when therapists come to aid victims, they must be aware of this fact and remember that the restoration of traumatic feelings sometimes causes re-traumatization, suffering, and possibly psychological repercussions (Barron, C., 2005).

Furthermore, an individual dealing with trauma undergoes an internal breakdown, where their typical defense mechanisms prove ineffective, leaving the core self-vulnerable to fragmentation. During this phase, the priority is to assist the individual through the initial stages of inner struggle. Subsequently, in the later treatment phases, once the core self has strengthened and is no longer fragile, it becomes advisable to proceed with debriefing."

Hochberg, in his article on journalists, a population frequently exposed to the most severe sights, discusses the mental damage caused to them as well as refers to soldiers who returned

from Vietnam. He argues that debriefing sometimes can be a real harm to trauma victims who need a place of gathering and not for further psychological breakdown (Hochberg, 1986, 2009).

Therapists transforming to combat supporters

An important additional unique aspect to consider is providing psychological assistance during combat and coping with continuous terror events and their consequences. The provision of therapeutic assistance during combat entails specific general principles. In common practice treatment settings, the primary goal in the therapy room is to alleviate the suffering and the post-traumatic symptoms of the combatant. However, from my experience, an additional goal during active combat situations is to prevent the mental breakdown of the combatant. Consequently, it's discouraged in combat situations to open up emotional content that often accompanies 'the text'. In other words, asking deep questions or linking descriptions to emotions is not suitable. In such cases, therapists should mainly focus on the order of events and superficially listen to the detailed descriptions.

When emotional content arises, it is recommended to address it with precision. The objective of the therapy is not to expand or delve deeper but to focus on consolidation and 'soul gathering'. Nevertheless, should a breakdown exhibit itself, it should not be overlooked but without the intention of healing. Following this principle, it is advised not to ask questions like "How did you feel when you saw those things?" or "What moved/ upset you?" More suitable questions in these situations are those focused on the concrete narrative, such as "What did you see?" or "What did you do?" The aspiration is to adhere to the combatant's order and course of actions. Moreover, if the patient is a returning/current patient in active combat; it's advisable to bring up from prior knowledge their known strengths in order to empower them. An additional reference is related to the spiritual dimension. Words of inspiration (not necessarily in a religious

context) and a vision serve as an extremely significant strengthening element in the treatment of soldiers in the field and are part of the actual treatment. The recommendations outlined above help the combatants to collect (vs. break apart) their core being as well as embrace them with the strength to continue functioning when facing challenging events, they are exposed to following terrorism.

One of the crucial aims in providing therapeutic support to combatants/civilians in the field is to serve as a "vessel" for the terror and horror content they cannot contain. Winnicott, in his article 'Transitional Objects and Transitional Phenomena,' explains the healing importance of the therapist's ability to hold the patient's emotions when they cannot (Winnicott, 1953). Often, these are topics the victims can't even share with their partners or their families, carrying them on their own. Such a container greatly alleviates the deep loneliness the combatants feel. Moreover, the very knowledge that another person can bear their horrors and terrors and can carry it with them is profoundly significant, conveying the message that somehow it is possible to continue living—a message that is not self-evident to someone who has been exposed to 'the end of the world.'

In a later stage of the treatment, after the core stabilizes, one statement that could aid the patient is the explanation and comprehension that, if permitted in therapy, to confront and touch a deep experience of depression and death, precisely from there, new powers will arise to be reborn. (Matsliach-Hanoch S', 2009). Additionally, in the advanced stages of therapy, it is important to search for a new meaning arising from the encounter with pain and suffering (Frankl, 1963). This will provide us with the strength needed to 'choose life' and survive the internal darkness and horror.

Another strong message conveyed in such a situation to the combatant is that someone is willing to listen to content they could not bear to carry on their own, meaning someone is right there to bear this horror for them. This strongly connects with the Kohutian theory that emphasizes the therapeutic importance of 'self-objects', which stresses the importance of one willingness to bear complex mental content for another. This process allows the combatant to gradually adopt and accept the therapist's bearing ability, eventually bearing it for themselves—a step toward healing (Kolka, R. 2005).

An additional important aspect of such treatment is to monitor the ever-changing mental states of the combatants and to encourage them. This involves closely observing their mental state and that of their friends in the field throughout the activity. Points to consider include whether an individual acts robotically without any moments of breakdown. Usually, after the clearance of bodies and areas where terror events occur, people operate robotically due to the required role. However, over time, situations arise where "the soul rests and stops", and moments of breakdown and connection occur. In cases where someone feels they 'no longer feel' or, conversely, feels at the 'edge of emotional collapse,' meaning they can't absorb anything further—no task, no comments from others, etc., encouraging them (if possible) to request a few hours or a day of rest is advisable.

The Warrior's Rest

Does physical rest necessarily allow for mental relaxation? In many instances, a soldiers' rest during combat does not equate to a state of calmness or relaxation for the mind. Typically, a warrior's rest during combat is not restful. Exposure to trauma grips the soul from within, resembling an ongoing film that continues to play, never pausing. Consequently, therapists need to guide warriors on how to cope with rest, which is sometimes harder than the combat itself.

Difficulties that arise during rest can include visions emerging into consciousness that the warrior didn't perceive earlier. According to literature, everything a person is exposed to during their lifetime is logged in the mind; even the things that weren't remembered at the time they were seen (van der Kolk, 2022). However, in extreme moments when gathering and action require, a survival mechanism is activated to allow performance under combat conditions, pushing these elements into the subconscious (Freud, 1987). Another challenge during rest relates to memories and emotions to unexpectedly surface, which were previously suppressed due to the action mode the subject was in, causing mental suffering. This event of 'Surfacing' occurs less during the action mode. Moreover, the variety of emotions that may overwhelm the combatant is extensive, ranging from guilt and anger to despair and anxiety for their family.

Coincidently: reality and imagination, the good and the bad

Based on numerous sessions held with soldiers, a recurring challenge they confront is the intermingling of imagination and reality, posing complexities in their experiences during service. This fusion often blurs the lines between memory, present circumstances, and imaginative perceptions, affecting their responses and overall encounters. For example, a soldier witnessing a child's body in the field may imagine their own child lying there, or, conversely, a soldier on leave hugging their child and seeing (imaginary) blood on their neck. It's not only the visual elements but also sounds and even words that cause confusion and chaos in the witnesses' internal experience. For instance, the use of the word 'party,' after the 'party' in a 'Reim' settlement where a mass massacre occurred, might evoke a mixture of emotions among the witnesses.

Preparation for Rest

From my experience in clinical interventions and research with both civilian victims and combat personnel, it is advisable to instruct and guide them to make plans prior to their official time off in order for them to be active during the recovery time from combat. For instance, one of the soldiers described to me how, during 1.5 days of leave and before returning to the field, he chose to hike in a spring with his family. Furthermore, it is pointed to inform combatants before going on a "recovery time" from combat is that they might struggle to rest or carry out basic activities like eating or sleeping. Amongst combatants exposed to horrors at times, an internal voice of guilt might raise and to make it difficult and hinder maintaining the daily routines. Therefore, it is crucial to encourage combatants to stick to their daily routines as much as possible. From my experience, therapists play a significant role in these situations; they represent the 'external voice' that combatants need to hear and are unable to articulate themselves: the voice that affirms the continuation of life itself.

Treatment in Times of Recovery - Therapist and Patient Together on a Sinking Ship

As described above, even in combat and in situations dealing with terror events, opportunities arise for therapists to treat civilians and soldiers during 'recovery time'. These therapy sessions are characterized by giving support to individuals exposed to extreme horrifying scenes. In these sessions, there might be highly acute situations, such as a 'breakdown' occurring during the therapy session itself. In such situations, the patient's anxiety significantly rises, possibly resulting in outbursts or some form of physical eruption not directed at anyone. The therapist should remember that in such a situation, the patient might feel misunderstood, isolated, and fear being considered 'crazy' or deviating from what is considered 'normal' by the public. In these situations, indeed, the environment often responds to the patient's anxiety, as if they

exhibit, they a form of psychosis: a terrifying state in which a person is in a state of distorted reality. This further complicates matters for the patient who is already confused themselves, and often fears whether they will ever be able to free themselves from the situation they are trapped in. In these cases, the therapist must strive to remain calm facing the patient's distress. This means that therapists must remain in the room during the patient's distress. For instance, not leaving to offer water to the patient or calling for additional assistance (which sometimes serves as a type of refuge for the therapist during a difficult moment). Additionally, it's advisable to refrain from comments such as "Please calm down" or "Maybe you should sit." Conduct such as leaving the room, calling for help, or attempting to calm the 'turmoil' only heightens the patient's anxiety and reinforces their belief that the situation they are in cannot be contained. The ability of the therapist to contain things not in apathy, but with understanding and the ability to "let the genie out of the bottle" is comforting and reassuring.

In order for a therapist to adhere to these recommendations, it is important to remember that an outburst is essentially a form of re-experiencing the horror and the story of trauma, not necessarily in words, and that, usually, it does not involve a dangerous deterioration. This understanding might influence and assist the therapist in containing this difficult situation. In such difficult situations, many therapists tend to use the 'mirroring' technique, which involves reflecting or mirroring the patient's words or behavior in order to mirror their state (Bramer, L.M. 1994). It's important to note that the mirroring technique should be participatory, emphasizing less on describing and reflecting the situation. Mirroring that describes the situation gives the patient a feeling that the therapist remains on the outside. For example: "I see your anger. I hear that you're sad." This implies that the patient is the one who is sad and angry, being observed and receiving reflections on their condition. This situation reinforces the patient's sense

of isolation and the feeling that they are not being seen as normal. Additionally, this situation also amplifies anxiety, as the patient might feel they cannot return to the realm of healthy individuals. On the other hand, participatory mirroring creates a sense that both therapist and patient are in the same boat, rather than the therapist observing from outside as the patient's boat sinks. Recommended responses for this scenario by the therapist would involve, for instance: "This is unbearable," "This is very difficult," and "My heart aches." Through such a gradual process, the outbursts will diminish. Furthermore, it is important to sustain a dialogue, and through this very act, convey to the patient that they have not lost their sanity but are dealing with a situation that is not 'Sane'. The aspiration is that, gradually, the therapist's perception will become the patient's self-perception. Further reducing the barriers between the therapist and the patient in these situations could also be achieved by offering personal acknowledgment such as: "I feel deeply for you," "I sense your pain," and "I pray for you." This personal acknowledgment sharpens the partnership and minimizes the gap between the therapist and the patient, eliminating the distinction between 'normal' and 'abnormal.' In addition to these, it is advisable to avoid assertive statements aimed at expressing understanding, such as, for example: "I understand what you went through." Because a person who did not witness the horrors must acknowledge the disheartening feeling of the patient, as "no one could understand what you saw," and that there is no cognitive or emotional ability to "understand" horrors.

When to treat

The first step in treating those affected by terror events under combat conditions involves examining the unique characteristics of the situation brought up earlier. What is the appropriate timing for initial treatment? Is it best to initiate such therapy when combatants return from active

combat or war zone, a month after surviving the terror event? Or once they've returned home post-events?

Based on my extensive experience working with individuals who have been involved in terror events under combat conditions, generally, during the initial stages, are not ready for treatment but require a reorganization of their lives. Reorganization refers to various aspects such as caring for meals, organizing how to explain to children what happened, contemplating and deciding about the ability to return to work, and finding solid emotional and physical ground to hold. The reason why combatants don't immediately start treatment is that it's not feasible to reopen the trauma before establishing a newly stable structure. Regaining a certain level of stability is a process that demands time (Chouraqui-Elfassi, 2006). For example, a patient sought treatment from me four years after an incident in which some of her family members were murdered while she herself was also targeted for murder. She came for treatment four years after the attack. Only then was she capable of speaking about and addressing ('touch') the trauma. I witnessed this phenomenon repeatedly for many years when I treated terror victims and held a managerial role in AVNT - the first association in Israel for terror victims. For months, and sometimes even in the first few years following the attack, people required going through the phase of organization and the construction of emotional and physical ground for themselves until they could talk about what happened to them.

Previously, prior to my professional career, I initiated meetings with terror victims across the country, which drew a large audience. Due to the overwhelming response, I invited clinical psychologists to guide the meeting. Surprisingly, no one showed up for the next meeting. However, in a subsequent informal gathering without therapeutic guidance, the entire audience returned. Over time, I realized that the difficulty in speaking and the time required before

witnesses could face the trauma 'face to face' manifested itself in various ways over the years. In this context, it's important to remember that the process of discussing the trauma in therapy doesn't occur under pressure but naturally, much like the development of human growth. While it's possible to encourage a baby's cognitive understanding, it's impossible to accelerate their maturity and intellectual comprehension. The same applies to the maturation within the therapeutic process. Attempting to hasten a patient's healing is not only ineffective but also carries a negative and harmful cost on the healing process (Chouraqui-Elfassi, 2006).

Summary

Terrorism affects various types of victims: Both soldiers and civilians are exposed to extreme and horrifying situations. Through these testimonies, therapists encounter stories of horror, complex behaviors, and outbursts, which they must manage while working in the clinic.

Additionally, the work of therapists during war and under terrorism is characterized by two main unique features: firstly, their role as witnesses exposed to horror and its effects, and secondly, the added objective of providing support to citizens and soldiers dealing with exposure to terror events and horror, who are situated in the field. This task requires the therapist to keep a particular balance between opening a channel for emotional discussion that leads to relief and preventing the psychological breakdown of citizens and soldiers who are likely to continue in combat. Therefore, the recommendation for therapists is to focus more on verbal content and assistance in self-collection and resilience and to use fewer methods of expansion and interpretation (Chouraqui-Elfassi, 2006). It is also recommended to delicately and accurately apply debriefing and mirroring techniques at the correct times as detailed above, and to be aware of the pitfalls of these techniques. This article further details challenging situations.

Moreover, this article describes difficult situations in treatment, situations of blurring between reality and imagination, and conflicting good and bad aspects at times. These situations are likely to arouse fear and distress among both the patients and the therapists themselves. Therefore, the article presents suggestions for interventions and strategies that may assist therapists in dealing with these difficulties. One recommendation is for therapist to keep in mind and understand that these severe outbursts of terror victims in treatment are essentially their way of narrating their trauma in a non-verbal manner and do not constitute a dangerous breakdown. This understanding might reduce agitation in the therapist and, consequently, in the patient. This process resembles the "mirror-phase" in a child's development, seeking to see and reflect themselves in their mother's eyes. The hope is that the child will receive approval to be 'whole and sound,' thus enabling them to continue living a complete life. In therapy, a state of correction like this can occur, where the therapist becomes the supporting arm for the patient, reflecting a calming rather than a disturbed image, conveying deep understanding and vitality. This way, the patient can confront these issues through a transformation from the external to the internal (Kohut, 2005).

The horrifying and disturbing events that occurred on October 7th bring us back to terrible times of pogroms and scenes of sadism seen during the darkest days in the history of the Jewish people. These scenes evoke a sense of "end of the world" in many ways. In these difficult days, a special national task of support, encouragement, and affirmation for the continuation of life is placed on the shoulders of the therapists.

References

Baum, N. (2012) Trap of conflicting needs: Helping professionals in the wake of a shared traumatic reality. Clinical Social Work Journal 40(1): 37-45.

Barron, C. (2015, January 27thth). When Not Talking About Past Trauma Is Wise. Retrieved from https://www.psychologytoday.com/ https://www.psychologytoday.com/us/blog/the-creativity-cure/201501/when-not-talking-about-past-trauma-is-wise

Boulanger, G. (2013). Fearful Symmetry: Shared trauma in New Orleans after Hurricane Katrina, Psychoanalytic Dialogues, 23:1, 31-44.

Bessel van der Kolk (2002) "The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma" Pardes Publishing

Bramer, L.M. (1994). "Helping Relationships, Processes, and Skills." Chapter 4: Help Skills for Understanding (pp. 88-124). Kiryat Bialik: "Ach."

Kinchin, D. (2007). A Guide to Psychological Debriefing: Managing Emotional Decompression and Post-Traumatic Stress Disorder. London; Philadelphia: Jessica Kingsley Publishers.

Cohen, E., Roer-Strier, D., Menachem, M., Fingher-Amitai, S., & Israeli, N. (2014). "Common-Fate": Therapists benefits and perils in conducting child therapy following the shared traumatic reality of war. Clinical Social Work Journal, 43(1), 77-88.

Clamente, S. (2022, December 22). Le défi consistant à revivre après un trauma. Retrieved from https://nospensees.fr/ https://nospensees.fr/defi-consistant-a-revivre-apres-trauma/

Chouraqui-Elfassi, Y. (2006). The Unseen Experience of Terrorism - Miracle or Disaster. (Master's thesis). The Hebrew University of Jerusalem, Jerusalem.

Cyrulnik, B. (2018). Traumatisme et résilience. Rhizome, 69-70, 28-29. https://doi.org/10.3917/rhiz.069.0028

Frankl, V. (1963). Man's Search for Meaning: An Introduction to Logotherapy. Kinneret Zmora-Bitan Dvir Publishing

Freud, (1987). The Ego and the Mechanisms of Defense, published by Zmora-Bitan

Hanoch, & Levi, A. S. (2009). Myths of Inverted Death: Depression as a Healing Power.

Herman, J. L. (1992). Trauma and Recovery. Am Oved.

Kolka, R. (2005). "Between Tragedy and Compassion." In H. Kohut (Ed.), How Does Psychoanalysis Heal? (Pages: 13-53). Tel Aviv: Am Oved.

Mazur, E., & Robine, N. G. (2013). Traverser une expérience traumatique. Cahiers de Gestalt-thérapie, (2), 100-115

Mitchell, S. A., Black, M. G., & Berger, M. (2006). Freud and Beyond: A History of Modern Psychoanalytic Thought. Tolat sfarim?.

Nader, K. (2001). Terrorism: September 11thth, 2001, Trauma, Grief, and Recovery. Retrieved July 9th, 2003, from http://www.giftfromwithin.org/html/firstaid.html

Ochberg, F. (1986). The victim of terrorism. In H. Ralph (Ed.), Coping with life crises: An integrated approach (pp. 367-376). New York: Plenum press.

Ochberg, F. (2009, March 24). PTSD 101 for journalists-terrorism. Trauma, Grief and Recovery. Retrieved from https://dartcenter.org, https://dartcenter.org/content/ptsd-101

Perry, P. (2014, September 25th). When talking about your problems actually makes them worse. The Guardian. Retrieved from https://www.theguardian.com/ https://www.theguardian.com/commentisfree/2014/sep/25/talking-about-problems-makes-them-worse-walter-mischel

Rothberg, M., & Kumm, Y. (1994). Seventy Facets of Life: Narrative Biography as Personal Psychotherapy. Bialik Institute.

Raphael, B., & Wilson, J. P. (Eds.). (2000). Introduction and overview: Key issues in the conceptualization of debriefing. In B. Raphael & J. Wilson, Psychological debriefing: Theory, practice, and evidence (pp. 1–14). Cambridge University Press.

Somer, E., Buchbinder, E., Peled-Avram, M., & Ben-Yizhack, Y. (2004). The stress and coping of Israeli emergency room social workers following terrorist attacks. Qualitative Health Research, 14, 1077-1093.

Smith, M., Robinson, L. & Segal, J. (2023, February 24th). The emotional response to traumatic events. Retrieved from https://www.helpguide.org/ https://www.helpguide.org/articles/ptsd-trauma/traumatic-stress.htm

Tosone, C., Nuttmann-Shwartz, O. & Stephens, S. (2012). Shared trauma: When the professional is personal. Clinical Social Work Journal, 40, 231–239.

Weiss, A. (2005). Social Work in Critical Perspective. Society and Welfare, 25, 249-28.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena. International Journal of Psycho-Analysis, 34, 89-97.