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Social Work in the Context of an Ongoing Security Threat: Role Description, Personal Experiences and Conceptualisation

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Abstract

In the wake of the recent increase in acts of terror and natural disasters, research literature has begun to focus more attention on situations in which trauma workers and their clients are simultaneously exposed to the same threat. However, less attention had been paid to the role of social workers in continuous shared traumatic situations. This article presents three case descriptions of events that emerged from social workers 'under fire'. The cases reveal that these situations oscillate from events that become routine, to events that combine extreme trauma and loss, and events that allow for the provision of assistance from broader elements of the community. The questions that emerged from the narratives call for rethinking and revision of conceptualisations of the role of social work and social work practitioners in war and emergency situations. To conclude, practical recommendations at all levels of intervention are offered.

Keywords: acute intervention, continuous traumatic stress, security threat, shared resilience, shared traumatic reality, trauma work

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Introduction

In the wake of the recent increase in acts of terror and natural disasters, research literature has begun to focus more attention on continuous traumatic situations (CTS) in conflict-affected zones such as areas of low-intensity warfare where there are frequent terrorist attacks, including attacks on civilian targets or attacks by repressive state forces that operate with impunity. Long-term exposure to possible or potential terror may also affect people's perceptions of risk or feelings of insecurity (Rosenberg *et al.*, 2008). Current research findings on adult populations living under a continuous threat showed that the contribution of fear reactions to post-traumatic stress disorder (PTSD) responses (e.g. emotional distress and impaired functioning) was more significant than actual exposure (Diamond *et al.*, 2010; Nuttman-Shwartz, 2014a).

Moreover, because people living under conditions of ongoing traumatic stress are currently in danger, their responses to the emergency situation, including avoidance and hyperarousal, can be understood as natural, protective and adaptive (Nuttman-Shwartz and Shoval-Zukerman, 2015). In those situations, trauma workers (including social workers) have reported that they temporarily shift their attention to the emergency. In some cases, however, the shifts in attention may have enduring effects on interventions as well as on their professional self-value (Baum, 2012; McTighe and Tosone, 2015) and family relations (Dekel and Nuttman-Shwartz, 2014).

Two main situations: 'shared traumatic reality' and 'shared resilience in a traumatic reality'

Recent literature has focused more attention on the problems that arise in the context of shared traumatic reality (STR). STR has been defined as the affective, behavioural, cognitive, spiritual and multi-modal responses that clinicians experience as a result of exposure to the same collective trauma as their clients (Tosone, 2012). These reactions have the potential to cause permanent changes in the clinician's existing mental schema and worldview. However, the primary experience of STR causes therapists to become potentially more susceptible to post-traumatic stress and leads to blurring of professional and personal boundaries as well as to increased self-disclosure (Tosone *et al.*, 2012). Findings indicate that, under these circumstances, therapists feel that their ability to help is impaired; they experience heightened work-related stress as a result of greater demands on their professional time, and feel that they are professionally unprepared for the situation. In

addition, the boundaries between their personal and professional selves are lost (Dekel and Nuttman-Shwartz, 2014; Tosone *et al.*, 2012).

Parallel to the growth process, the concept of 'vicarious resilience' (VR) provides a basis for considering how the stories of trauma survivors may also sustain and empower workers, and is congruent with many of the strengths-based approaches to practice (Cohen *et al.*, 2015; Hernandez *et al.*, 2007). This concept suggests that, if the trauma workers are open to and aware of the potential and utility of VR, their ability to reframe negative events and coping skills may be enhanced through work with trauma survivors. Research findings have shown that therapists who succeed in finding new methods of intervention which help both their clients and themselves have reported an increased sense of competence (Dekel and Nuttman-Shwartz, 2014). In addition, a supportive environment and a part-time position can also enhance the therapists' ability to develop VR in their work with disadvantaged and traumatised populations as well as in STR situations (McTighe and Tosone, 2015; Stevenson *et al.*, 2011). The clients' growth can strengthen therapists, and can enable them to cope more successfully with the same traumatic events, which has been conceptualised as 'shared resilience in a traumatic reality' (SRTR) (Nuttman-Shwartz, 2014b).

Against this background, in this article, we will present case descriptions of events, thoughts and practice that emerged among social workers 'under fire'. In addition, we will present conceptualisations and questions that call for rethinking the role of social work and social work practitioners in war and emergency situations.

The context

Since 2001, Israel's western border with the Palestinian Authority has been the target of more than 10,000 Qassam rockets and mortar attacks. Over the years, the Israel Defense Forces have engaged in three operations: one in early 2009, the second at the end of 2012 and the third during the summer of 2014. Following each operation, the number of missile attacks decreased dramatically for a short period. After the first two operations, however, missiles were fired again, and the residents of the area have continued to be threatened. Although Qassam rockets are relatively unsophisticated weapons with low accuracy and low deadliness, the frequent firings at all hours of the day and night have generated considerable uncertainty and anxiety in the lives of the residents of the stricken area, and have led to a heightened state of physical and emotional alertness (Dekel and Nuttman-Shwartz, 2009). Because the interval between the time the missile is fired and the time it lands is very short, there is little opportunity for self-

protection. People abruptly stop what they are doing, run for shelter in inadequately protected areas and wait for the boom.

In these continuous and recurring situations, there is a need to deal not only with the physical and emotional damage in the immediate aftermath of the attack, but also with the long-term stress evoked by the constantly looming threat (Braun-Lewensohn *et al.*, 2009; Nuttman-Shwartz, 2014a). Findings of research on this topic indicate that approximately 26–27 per cent of the development town residents have reported experiencing PTSD symptoms, compared with 6 per cent of the residents of rural communities in the area (Besser and Neria, 2009; Nuttman-Shwartz and Dekel, 2009). Depending on the nature, intensity, extent and duration of continuous shared trauma, social workers can respond professionally and personally in a myriad ways, and each one affects the other.

The following vignettes illustrate the complexity of the social worker's role(s) in situations of continuous STR. The narratives were written by an experienced local social worker and a seasoned academic social worker, both of whom have been subjected to Qassam missiles near the Gaza border for years.

It is important to note that both authors are social workers with a Ph.D. degree. They have worked in the field for over thirty years and have extensive knowledge and experience, including experience with stressful situations in particular. One of them was involved in developing and initiating the emergency social services in the area, and served as director of one of the resilience centres, including during a major military operation in 2009. Since then, she has continued working under the auspices of the resilience centres in the area with families, adults and children. The second researcher founded the school of social work in the area, and was the first head of the school. In that capacity, she was involved in developing professional knowledge, new concepts, interventions and policies as well as in training for the trauma workers in the region. At the time at which the threats escalated, she volunteered to work at several resilience centres in the exposed area.

During this period, both researchers documented critical events, including the cases presented in this article, which are those that we considered to be most meaningful. These cases represent events which combined a sense of extreme personal threat and even fear of death. As such, they reflect STR dilemmas which were also voiced by our colleagues. However, because we are both from the exposed communities, we might have had difficulty observing and analysing the cases, not just in terms of self-reflection, but also in terms of the STR situation. Nonetheless, we hope that our extensive experience in the field helped us to adopt a broader perspective.

Case descriptions

First event: 'Time is like a Ferris wheel'

The first event took place when the social worker was in charge in one of a the resilience centres on the Gaza border:

> The event described here occurred on a day when we, all of the helping professionals in the department, were attending an in-service training course on intervention in emergency situations. We were still at the course when we received a message on the MIRS phone that three mortar shells had exploded in a factory at one of the kibbutzim in the area. The factory is located near the border, and employs dozens of workers. There were casualties.
>
> My heart started pounding; my pulse was racing, and my thoughts were running in every direction: 'What do they mean by casualties? Were people killed? How many? Who? What should I tell my own family? How can I watch out for my own personal safety? Will I be effective? Will I succeed in helping? Who should I contact? Who are the best people to go out with to the scene of the attack? Who else should I share this information with at this stage—both in order to be efficient and in order to keep myself safe?'
>
> The transition from the mindset of a participant in a course who is going through another work day in the familiar 'emergency routine' to a professional in an actual emergency situation requires cognitive flexibility. The transition process takes place quickly and is almost automatic. I say to myself, 'this is the moment to pull out the protocol that we've learned and been trained to implement all these years':
>
> So, first of all I pause to pull myself together; I take a deep breath, go to the bathroom, drink something, think ... phone my husband and tell him what I'm supposed to be doing in a few minutes. Then the department director and I always decide together who will go out to the scene and who will stay behind to continue managing the event [i.e. who will gather more information and assess what else is needed]. I go out to the scene with two of my social worker colleagues.
>
> I get to the factory, and in the yard I see the media, ambulances, scared employees. Dozens of workers are gathered in a room that is relatively protected. I know the protocol by heart, [so] I join the manager of the factory and the woman in charge of personnel, and they brief me on what happened when the missile fell. It turns out that one member of a kibbutz in the area was killed, and two people were injured. In addition to the team that has already arrived at the scene, two more social workers are rushed to the factory in order to assist the family and community of the person who was killed. According to the 'community assessment' prepared by the staff of the factory, there are seven shock victims [people with acute stress response (ASR)] who need to be treated. We [the social workers who arrived at the factory] receive rooms that were vacated in

order to intervene with people who have been defined as 'shock victims'. I ask the manager of the factory how he is feeling and evaluate his condition (an important intervention that we always engage in throughout the event). Afterwards we instruct him to keep the staff in the protected area and prepare to distribute hot and cold drinks and refreshments. Then he is asked to describe the chain of events, and what steps the factory is taking to continue helping the workers.

At the kibbutz of the person who was killed, the social worker consults with the kibbutz members in charge of social affairs, health, and education and engages in needs assessment: The family members of the deceased need to be taken care of and their basic needs need to be provided for (e.g. food, arrangements for the funeral and the shiva [seven-day mourning period]). The kibbutz children will be returning from school in about an hour. According to the protocol, which I can see right in front of my eyes, this is the time that we have to make preparations to work with children of all ages. Some of the interventions have begun inside of the school (e.g., informing the children about the event, giving them a space to vent their feelings and share their fears, and encouraging them to ask questions and contact their family members). The kibbutz infirmary has reported that three veteran kibbutz members are experiencing ASR symptoms.

With the assistance of volunteers from the community who have been trained to deal with these situations as part of the 'emergency routine', and with the assistance of the psychological services and trauma workers from the resilience center, we make preparations to respond to the needs of casualties that have been identified and defined at every level. Psychologists from the psychological services and school counselors make sure that responses are also provided for children from the neighboring kibbutzim.

In the afternoons, the various therapeutic teams convene. Again, according to our protocol, we evaluate how all of the trauma workers are managing. The situation is reevaluated, and the community's ability to continue managing the situation on their own until the following morning is examined. It is decided that a small team from the resilience center will stay to support the staff members of the kibbutz and the family of the deceased.

In the evening there is supposed to be a wedding—a woman from this kibbutz is marrying a man from my place of residence. … I go home, try to pull myself together, to process the events of the day … from the morning when I attended the course on coping with grief and loss, and until this moment. I do some of the breathing exercises that we have learned. I'm filled with intense sadness about what lies in store for the family and the entire community. I also think about what we will have to deal with as a team. I get to my place of residence, go past the entrance gate and drive toward my house. The first cars are leaving for the wedding. I enter the house, take a hot shower, wash away the events of the day (at least on the surface), I go out to meet my good friends, to

congratulate them, to prove that life goes on and that maybe things will be good … it's a strange encounter … seems surreal. Where was I this morning, and where am I now?!. May I and everyone else continue to use the resources we mobilized today in order to get through the difficult, complex days that lie ahead.

Second event: 'One's heart will open to another'

The event took place during a military campaign waged by Israel against the Palestinians. I was a volunteer social worker on the staff of a nearby academic institution, and was working at the resilience center in one of the localities in the area. The phone rang, and 'A' was on the line. His voice was shaking. 'A' is a lonely 45-year-old man. He was scared to go to the shelter in his home despite repeated air raid sirens. He mentioned that for several days he had been sitting at the entrance to his house and was unable to take care of his basic needs. For the first few minutes of the conversation I encouraged 'A' to tell me more about his situation: 'I have been sitting by the door for three days, haven't showered, haven't eaten … I've been drinking a bit … I am scared, really scared.'

I debated about making a house call despite the missile attacks. After talking to him for a few minutes, I continued to assess his situation. For the most part I focused on 'A's' ability to ask for help from friends and neighbors. When I understood that at this point I wouldn't be able to persuade 'A' to get help from his neighbors, and in light of the severity of the situation he was describing, I decided to take the risk and make a house call. I told my colleagues at the resilience center that I would be going to 'A's' house so that they would know where to find me if I'm hurt. Fear enveloped my whole body … thoughts about my family …. At the same time, I tried to understand 'A's' situation. I got there quickly. No one was on the road … the silence was eerie … I followed instructions and drove with the radio on in case there would be sirens.

Just a few minutes later I found myself in an old building with a narrow hallway … a few neighbors in the building went out to see where the last rocket had fallen. 'A' was waiting by the door and hugged me when I came into his apartment. For a long time I sat with him on the floor, because there were repeated air raid sirens. Between the sirens, I suggested that we go down to the shelter together and see if he can sit there with the neighbors. It was tense in the shelter. There were three families and about 15 people. 'A' definitely looks different than his neighbors, but I thought that this is where he should be. I asked all of the adults to help him. One neighbor, 'M', an energetic woman who works as a kindergarten teacher, hugged 'A' and told him: 'You are part of my family …. As an adult, you have to set an example for the children and show them that we're all here … staying in the shelter.'

During the course of the conversation, the tenants made more requests for basic supplies, activities for the children, etc. After identifying their needs, we allocated tasks to the adults and children. The adults would organise purchases and supplies for the shelter, the older children would organise activities for the younger children, and I would organise student volunteers to come to the shelter and lead activities for the children. The visit to the shelter was an opportunity to assess the needs of other populations, to pool community resources such as students who had received supervision in leading activities for children and following up on the situation of the families over time. As a social worker, I was now free to handle my next task at the resilience centre. I phoned 'A', and he reported that his situation had improved considerably.

Third event: When the threat is a painful reality that continues for a long time, and there is close partnership and involvement

Qassam rockets had been fired at the area for a few weeks in the summer of 2014, before the last war between Israel and Gaza was officially declared. The third event, which took place at that time, was described to us by a social worker in the regional council, on the border of Gaza.

The following is the social worker's narrative of the event:

> On that day, I take my four daughters out for a short break. They have not experienced a mother that whole difficult summer. We had talked a lot about needing breaks, shift work, and treatment of therapists while events are taking place. For me, 'treatment of the therapist' is quality time with my daughters. They're supposed to start school next week, and my six-year-old still doesn't have a schoolbag to use when she starts first grade. So I take the four of them to town, hoping to have a little peace and quiet, to get away for a while from the events, the experiences, the obligations …. All I want is to try to feel a bit of normalcy—just for a moment …. We are at the store, and my daughter tries out the schoolbags … she selects a few, wants to find the cutest one, the most awesome one, the pinkest one in the store. Then I start hearing voices over the regional MIRS system … reports … an attack at the fence of the Kibbutz … there are casualties. That's it. No more peace. I need to 'shift gears'. First thing: The girls stay in the store … I switch to emergency mode. I'm in a nearby coffee shop and 'open up my private war room', which means that I open the MIRS system and turn on my private telephone. I try to get information from my colleagues, try to read and understand the information, and try to get the latest news about the situation. In less than a minute I make a decision: the girls will go to my mother and sister in the central region. I need to plunge into the tasks at hand. Unfortunately the schoolbag has to wait … there are six more days. We'll find time before school starts. The minutes pass. I'm talking

to the department director. Over the phone, we do a preliminary assessment of immediate needs: three social workers have already left for the locality. I'm in the central region now, so I'll head up the northern region, where half of the community members were evacuated since the beginning of the escalation.

I head north. I know the road. I'm running on autopilot, try to clear my head and prepare myself emotionally, I tell myself that I remember our practice and training sessions. First of all I pay attention to my breathing; then I collect my thoughts, plan what to do when I arrive there. I keep the phone free for incoming calls. I continue to gather facts and assess needs over the phone, focusing on the community that is staying at the temporary accommodations. This is the first time I'm managing an event outside of the area … the first time I am developing an intervention that is not based on a broad perspective which covers all of the sectors and areas at once, I'm focusing only on one sector in the overall map. One person was killed—he was a security officer and I have known him for several years because our jobs overlap. Of course I also know his wife, and due to the circumstances I'm going to meet her in a few minutes. I free myself for a moment, so that I can mourn on my own—the profound grief over what has happened to us … over this long, difficult summer that has caught us again at every level: at the personal level, at the level of my family, at the level my small community where I am living and raising my daughters, and at the level of the broader regional community that I am committed to as part of my professional role. I'll be seeing the members of the community soon—the widow as well as her close friends. Lots of kids are there from the kibbutz … kids of all ages. We'll have to take care of them, explain to them, talk to them, calm them down.

I arrive. First I join the leaders of the divided community at the temporary locality and get information from them about their community. Then I meet the widow's friends … the women are tired, sad, in shock, can't understand how this happened. How can it be that our security coordinator, the person who symbolized our personal and community resilience … how can it be that he was the one who sacrificed his life?

I take another breath …. Following the protocol, the community leaders and I work together on developing and implementing a plan for intervention with the widow, the children in the bereaved family, the children in the community who are at the temporary locality, and the adults at the temporary locality. The time passes…..we try to cover as much as we can …. It's already 2:40 AM. Slowly people disperse and go to their sleeping accommodations. I discover that I don't have anywhere to sleep. A member of the temporary community comes to help me (does she happen to be a social worker?). She gives me a clean bed, a nightgown, and a towel. I go to sleep, constantly thinking about the sadness I feel as a resident of the region, as a mother of four young girls, as a friend and partner of the bereaved family and the entire community. Did we make the right choice? Will we continue to have a

> constructive, creative, and active life? Will I be able to continue in my role? Will I choose to do that? Will I be enthusiastic about it? Will I have the same sense of mission as before? Soon it will be morning. Another difficult day lies ahead. Whatever decisions we didn't get a chance to make today, we'll make tomorrow.

Discussion

Working 'under fire' in the context of terror attacks and war, as reflected in the situations described above, poses challenges for social workers, who are expected to function in a violent reality (e.g. Joseph and Murphy, 2014). In this context, it is accepted to adopt specific regulations and protocols for intervention in situations of stress and in emergencies (Shalev *et al.*, 2012). Experience has shown that an extensive set of guidelines and regulations has been developed over the years in Israel and abroad, which include a broad, multidisciplinary system of local and national social services. As we can see in the above examples, the experienced social workers already internalised and followed the trauma protocols, even though the events were very stressful.

As in other cases, there is a clear need to consider the professional implications of this reality, which include implications for professional decision making as well as implications for the STR of social workers and the people they assist (Band-Winterstein and Koren, 2010; Baum, 2012; Tosone *et al.*, 2015). STR exists at the personal, family and professional levels. On the one hand, for example, the social workers in the first and third events described above wanted to normalise their lives, as reflected in one worker's desire to join the community in a celebration and in the other worker's desire to spend the day with her daughters at a shopping mall. On the other hand, they needed to provide assistance and deal with traumatic events that affect the community, such as breaking tragic news to a colleague and friend. The blurring of roles requires considerable flexibility and professional maturity (Dekel and Baum, 2010). As seen in the above cases, we recommend that trauma workers be allowed to oscillate between their personal and professional roles, as well as between their own experiences and their clients' experiences. The ability to oscillate in this way has been found to be effective in shared traumatic situations (Cohen *et al.*, 2015).

Over the years, we have learned that, in emergency situations, staff members should have professional experience and awareness, and staff members with families should have older children. Workers without children at home who go out into the field in emergency situations are much more competent, available and able to focus on the needs of the population than workers with children at home. Therefore, it is important that the staff include a high percentage of older workers. We

recommend that, rather than engaging in direct intervention in the field, staff members with young families work 'from a distance', such as from their homes or if possible from the resilience centres, and provide support to colleagues who need to vent on the phone. The younger workers will be more effective and contribute more to the functioning of the staff if they engage in activities such as mediation and contact with the authorities, or if they fill in for the older workers and enable them to take a break. The younger workers can also help the communities and residents who have been evacuated from the region to a safer area, and can even accompany them together with their own young families. These approaches could enhance the workers' sense of being part of the activities of the staff after the event. They should be able to make assessments with long-distance managing, so that from time to time they can stay on the sidelines and encourage others to take over on the front, and vice versa, in addition to using outside professionals and volunteers who can facilitate processes that will reduce the intensity of the event and who can offer comprehensive assistance (e.g. in Case 2).

Nonetheless, consistently with the findings of recent studies, the case descriptions indicated that general personal and professional experience and the specific experience in the field of trauma, as reflected in knowledge and internalisation of trauma protocols and the ability to use them in a flexible way, are important components that enabled these professionals to offer assistance. This is also a condition for developing personal and professional resilience (Bauwens and Tosone, 2010; Bonanno, 2004).

As in the first case, issues such as what is considered as professional and what is considered as overstepping boundaries due to processes of counter-transference and identification need to be reconsidered in light of the complex context of a continuous STR (Tosone *et al.*, 2012). As such, flexibility is also required at the level of the setting, including the intervention methods, the actual interventions and the professionals who conduct the interventions. In situations of this nature, professionals who do not belong to the service are often recruited for the interventions (e.g. in Case 2). As shown, the interventions are not conducted in the regular or accepted settings, and they sometimes involve people other than professionals, such as emergency service workers and even volunteers. This approach is desirable, because it enables services to be provided to a large sector of the population, and it can be helpful in reducing vicarious traumatisation and compassion fatigue responses among trauma workers in emergency situations (Joseph and Murphy, 2014; Saari *et al.*, 2011).

It would be worthwhile to consider establishing a system of support for those who provide assistance, in addition to helping them return to a work routine after the emergency. Unfortunately, the events described here occurred in an environment that is exposed to a continuous security

threat. However, between the periods of violence, there is still low-intensity violence as well as totally quiet periods. As indicated in the literature, this situation has been conceptualised as an 'emergency routine' (Baum, 2012). In order for social workers to show role oscillation and to be able to move between these domains of activity, it is necessary not only to provide appropriate training, but also to be attentive to their changing needs, to identify workers in distress, and to develop networks of personal and professional support. Research findings have shown that direct and indirect supervisors can play a key role in emotional regulation and in providing social workers with emotional containment and support (Cohen *et al.*, 2015). In addition, findings have indicated that providing social workers with ample training, support, information and resources plays an important role in mitigating the impact of stressful events on social workers in STR (McTighe and Tosone, 2015).

This raises questions about training a broader range of people to provide assistance, as well as questions about the need to develop communities that provide support in emergency situations and the need to rely on volunteer staff. The fact that these are situations of war and emergency highlights the need for organised provision of primary, intermediate and advanced training in trauma, crisis, and disaster mitigation and preparedness, as well as the importance of familiarity with the population that receives assistance (Joseph and Murphy, 2014; Saari *et al.*, 2011). At the same time, the professional teams need to have an opportunity to take a break, and they need to reach a balance between the intensity and the persistence of the situation as described in the present article.

Even though social workers are prepared for emergencies, and particularly for continuous security threats, there is a need to consider processes of burnout and secondary traumatisation. These processes are known to characterise social workers dealing with clients who have experienced trauma, especially when the workers are directly or indirectly exposed to those situations in their encounters with clients as well as in their families and in their parental role (Cohen *et al.*, 2015; Figley, 1995). The above cases show how this knowledge might shed light on the importance of professional experiences in general and trauma work in particular as factors that enable them to function. In the above cases, as in the aftermath of the 9/11 attacks, the professionals who provided assistance had extensive experience in trauma work (Bauwens and Tosone, 2010; Tosone *et al.*, 2011).

Regarding the levels of intervention, it is essential to understand that the damage essentially affects all spheres of the community, and that assistance at one level will project to the next level. As such, it is important to consider the community as a whole, which is recognised today as an essential component for promoting resilience (Bonanno *et al.*, 2015; Ungar, 2013). In this connection, social workers play a key role in all

stages of the intervention. Although the cases presented above involved acute interventions which always call for mobilisation of special assistance, they highlight the importance of familiarity with the community, advance preparation and enlistment of the stronger members of the community to assist those who are in a more difficult situation (Joseph and Murphy, 2014). These cases show how the social services in the region have learned to pool resources with institutions of higher education and recruit assistance from academic staff members as well as from students who are in the process of training. To the best of our knowledge, these attempts to ease the burden of professionals by mobilising community resources are in line with the community resilience approach (Ungar, 2013), which has not been examined in existing research. However, it appears that those who have implemented this approach have had a positive experience, and that this model might be used to ease the burden of social workers through the provision of appropriate training for volunteers. It is important to bear in mind that people like the factory managers mentioned in the above case also need to be trained and supervised by social workers and social services.

Finally, in line with the findings of the studies described here, STR and a state of war increase levels of direct and indirect exposure to threats in the therapists' families, which in turn increase the therapists' concern for their families. Experience has shown that responses such as day-care, neighbouring or adopted families, and even family and couple treatment should be provided for the social workers so that they can be available for their professional work. Studies have shown that workers in the field have found personal solutions, but most of them have guilt feelings and other complex feelings about their families (Baum, 2012). In that connection, advance preparations and solutions that take the social workers' families into account can help them function in emergency situations and afterwards—even though social workers have reported relatively high levels of functioning and low rates of distress (Dekel and Nuttman-Shwartz, 2014).

Another complex aspect of the above-mentioned situations derives from the need to combine traumatic crises with events that include loss. As mentioned, the distinctive knowledge required for interventions in each of these contexts has been addressed in the literature. Social workers in combat zones need to have extensive knowledge about life situations and intervention methods. The aspect of loss can significantly heighten sensitivity and intensify the difficulty involved in coping with these situations alone. Although the guidelines address the role of social workers in providing immediate assistance in emergencies, compulsory training for these roles is necessary (Berger, 2012).

Before concluding, several limitations of study need to be addressed. First, it was based on a reflective analysis of three cases documented by trained and highly experienced social workers, whose families were

independently functioning (e.g. their children were young adults living on their own), so they were able to devote themselves to the traumatic events. Because these were extreme cases that occurred during two different periods of terror escalation, it is important to continue looking into ways of working with young social workers who have less training in different types of traumatic events. Notwithstanding the limitations, the present article gives a voice to the field workers which highlight the importance of recognising their intensive work in STR situations and helping them work through these traumatic situations. The conceptualisations presented here can also be used as a professional way of echoing and understanding their situation, and enabling them to better prepare for the upcoming events.

Specifically, social workers need to:

1. be trained for work in emergencies—for breaking tragic news, following protocols, assessment, evaluation and intervention, in addition to having a high level of mastery and task functioning; this might include: practising simulations of emergency situations and practising the necessary skills (obtaining relevant information, locating vulnerable spheres), allocating the staff necessary for each sphere separately and all of the spheres together, and providing responses through calming interventions (anchoring, normalisation, providing for basic needs and teaching the staff members primary methods for calming interventions such as breathing and Somatic Experience);
2. be flexible about work styles and work situations, and be able to 'shift gears' rapidly from routine situations to states of emergency, trauma and loss; from acute to chronic situations; from the role of professional to the role of family member and vice versa;
3. be aware, and learn to use the positive aspects to enforce growth and resilience;
4. be able to recognise the importance of intervention beyond the level of the individual, and to pool professional and paraprofessional resources;
5. be able to work as part of a multidisciplinary team, to create and accept partnerships beyond familiar colleagues and professionals;
6. be aware of and prepared to deal with self-anxiety reactions and impaired personal functioning, and recognise situations in which workers are not available for others or for professional work, whether this is due to a temporary emotional burden or due to the development of symptoms of illness;
7. create spheres of self-care by obtaining professional support from the department director, managers of teams, social and local services as well as from spheres of personal support within the family and spheres of social support; if necessary, even offer therapy to the social workers themselves; and

8. publicly recognise professional interventions and activities that will lead to professional and social recognition of activities in emergencies.

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