Therapeutic Intervention in a Continuous Shared Traumatic Reality: An Example from the Israeli–Palestinian Conflict

Tamar Lavi[1],*, Orit Nuttman-Shwartz[2], and Rachel Dekel[3]

[1]*Sderot Resilience Center, Sderot, Israel*
[2]*The Israeli National Council for Social Work, School of Social Work, Sapir College, Shaar Hanegev, Israel*
[3]*Louis and Gabi Weisfeld School of Social Work, Bar Ilan University, Ramat-Gan, Israel*

Correspondence to Tamar Lavi, Ph.D., 109 Morag St, Newe Mivtah, Israel. E-mail: tamar@lavi.ws

Abstract

Growing political instability around the world has exposed an increasing number of communities to military conflict. Social workers and other mental health professionals who work as trauma workers, and who both live and practise within these communities, are doubly exposed: directly and indirectly, personally and professionally. The present study examined the consequences on trauma workers and on the therapeutic process itself of working in a continuous Shared Traumatic Reality. The study was based on content analysis of three focus groups conducted among thirty trauma workers, between the ages of thirty and sixty, who were trained in a variety of therapeutic professions, mainly social work. Findings suggest that a high level of exposure to life threats and emotional distress can coexist with high levels of professional functioning and resilience. Results further point to complex implications associated with therapeutic relationships and settings that include: diminution of the transitional space, strengthened sense of identification between workers and clients, and acceleration of the therapeutic process. The discussion reviews the variables that facilitate and impede the professionals' functioning and highlights the unique effects of continuous exposure.

Keywords: Shared Traumatic Reality, terror, trauma, trauma workers, interventions

Introduction

The literature focusing on trauma workers with traumatised clients has long recognised the profound, pathogenic and long-lasting toll such work takes on professionals who practise it, such as secondary traumatisation, compassion

fatigue (Figley, 1995) and vicarious traumatisation (McCann and Pearlman, 1990). However, when those professionals both live and work in the same community as the people whom they serve, they are exposed to and threatened by the very same traumatising circumstances as their clients. This situation has been referred to in the literature as *Shared Traumatic Reality* (STR) (Nuttman-Shwartz and Dekel, 2009). While this phenomenon was noted in the literature as early as the Second World War, during the 'Blitz' in London, and in Israel during the 1991 Gulf War, it began to receive extensive attention and conceptualisation only in the aftermath of the 9/11 attacks on the World Trade Center (Baum, 2010).

The literature on STR in relation to war and terror (Baum, 2010; Nuttman-Shwartz and Dekel, 2009) and in the aftermath of natural disasters (Tosone *et al.*, 2011) revolves around three major aspects of the STR: the workers' personal and direct exposure to trauma, the effects on their professional work, and the conflict between their personal and professional worlds.

Saakvitne (2002) suggests that the trauma workers' personal exposure within the reality of shared trauma is three-fold: they are personally and directly exposed to life-threatening events and the horrors associated with them; they worry about loved ones and patients exposed to the traumatic events; and they are indirectly exposed to the traumatic events and anxiety via their patients through the therapeutic process. Some researchers—such as Wee and Myers (2002), studying mental health professionals who provided psychological aid following the WTC bombing, or Baum (2012*a*), who interviewed Israeli social workers following two major military conflicts in 2006 and 2008 in Israel—found elevated levels of distress, anxiety and post-traumatic symptoms, and attributed them to the professionals' direct exposure to trauma and concern for loved ones. Other researchers, however, point to high levels of resilience (e.g. Krug *et al.*, 1996).

In several studies, social workers report that conflicts of loyalty arise as they feel bound to choose between their professional obligations to clients and their needs/wishes to remain beside family members and loved ones during an emergency (Somer *et al.*, 2004). In many cases, they need to make a quick transition from the private to the professional domain—a demand that is complex and not always fully achieved, as professionals report having difficulty in devoting their full attention to their clients during emergency phases. Many report experiencing vivid and intrusive thoughts and images of their own families during their work with their clients and terror survivors (Somer *et al.*, 2004). Most of the social workers view these episodes as situational failures of empathy related to the traumatic events; however, some experience an elevation of guilt and shame, and a lowered sense of self-esteem and professional value due to their inability to be fully attentive to their clients (Baum, 2012*b*).

The literature on the effects of STR on the work mostly describes the blurring of therapeutic settings and boundaries. The emergency phase, which necessitates changes in the mental health professionals' roles and obligations

(Dekel and Baum, 2010; Tosone *et al.*, 2003) as well as the physical settings in which their work takes place, also requires an immediate implementation of flexibility and creativity on the workers' part. For some, the abrupt changes in the settings and roles are distressing (Lev-Wiesel *et al.*, 2009) and they may report high levels of helplessness attributable to the scope of the disaster (Eidelson *et al.*, 2003), the pain and suffering endured by the victims (Cohen *et al.*, 2006) and the social workers' own sense of exposure to danger while in the midst of offering mental health assistance (Shamai, 2005).

Furthermore, the shared vulnerability places both partners of the intervention process on an equal footing. Mental health professionals reported on their efforts to help patients while their own wounds and fears were still raw. They are unable to pull themselves out of their patients' subjective worlds (Seeley, 2003) and find it more difficult than usual to separate their lives from those of their patients (Tosone *et al.*, 2012).

Notwithstanding the existing knowledge about the concept of STR, little is known about the consequences of a *continuous* STR on trauma intervention. Our study aimed to deepen the understanding of what happens when emergencies and life-threatening situations are experienced repeatedly over a decade, becoming life routines that demand shifts and flexibility on the part of all of the participants in the intervention process.

The Israeli–Palestinian conflict has been ongoing and continuous since the establishment of the state of Israel in 1948, inflicting pain, grief and sorrow on the lives of people on both sides of the border. Our study focused on the Israeli population settled along the south-west border with Gaza, the target of frequent and random rocket attacks (more than 10,000 to date) that have taken place at all hours of the day and night for more than a decade. During these years, the IDF (Israel Defense Forces) and Hamas (the military wing of the Islamic Resistance Movement) have engaged in several military operations, three of which led to massive fighting and ended with no political resolution. Israeli settlements along the border have suffered damage to property, physical injury and the deaths of twenty-six Israeli civilians, including four children. (*www.btselem.org/hebrew/israeli_civilians/qassam_missiles*).

Alongside the physical injuries and deaths, the continuous and recurrent exposure to the shelling has also taken an immense emotional toll on the populations. Studies conducted in the area show that residents of the region reported a heightened state of physical and emotional alertness and psychological symptoms related to distress (Besser *et al.*, 2009; Diamond *et al.*, 2010).

In an attempt to provide aid, the country's social service and health agencies initiated the development of 'resilience centres' throughout the region. These centres aim to offer the population additional mental health services, as they specialise in trauma and distress responses. The working paradigm of these resilience centres is recruiting a multidisciplinary staff (social workers, psychologists, art therapists, etc.) and providing them with extensive training specific to emergency and long-term interventions in situations of ongoing

trauma. Since the resilience centres function under the auspices of the Ministry of Social Affairs (also in charge of social workers in Israel), most of the mental health workers within the centres are acting and working as social workers; that is, they perform social work tasks with only slight differences resulting from their original training. Additionally, most of the staff members reside within the region and are exposed to the same real threats to their security as their clients are.

The following study focused on the consequences of the continuous STR on the intervention process, the therapeutic bond and the professionals' sense of competence. Questions asked included: How do multiple infiltrations of reality into the therapeutic space affect the intervention process? How might the professionals' attempts to manoeuvre their lives around a routine of life-threatening experiences influence their work? And what role does anxiety play when both worker and client experience it mutually throughout the intervention?

Method

Data were collected in three semi-structured, in-depth focus group interviews, each of which lasted around three hours. The group interviews were conducted in Hebrew, recorded, and later transcribed and translated into English.

Participants

Thirty trauma workers (five men and twenty-five women), ranging in age from thirty to sixty years, participated in the study. These individuals were employed in a variety of mental health professions: eighteen social workers (60 per cent), six psychologists (20 per cent) and six art therapists (20 per cent). As all of the participants were trained to work with people who had been exposed to traumatic events, we refer to all of them as 'trauma workers' (Cohen and Collens, 2013). The duration of their employment in the region ranged from one month to twenty years. Most had been employed in the field for more than five years. All of them were also parents of children ranging in age from infancy to twenty. A few (3 per cent) were grandparents. Over 75 per cent (twenty-three) lived in the region. Participants were employed by three agencies: two regional resilience centres (twelve and nine participants) and one municipal social service agency (nine participants).

Procedures

After receiving the directors' consent, the authors arrived at a staff meeting, introduced themselves, described the research and asked for permission to

record the interviews. Each group was led by two of the authors. The authors were careful to ensure that all of the interviewees had an opportunity to express themselves. This study was based on the anti-oppressive perspective that people are experts on their own lives and work (Strier, 2007). All of the trauma workers in the resilience centres were invited to participate in the study, with no differentiation made on the basis of gender, profession, seniority or any other characteristic. The goal was to make the study as inclusive as possible—in order to thoroughly capture the work being done—and also to minimise the possibility of identifying the participants, or of any discrimination.

Ethical considerations

The research was approved by the Institutional Review Board (IRB) of the Sderot Resilience Center, and all of the participants voluntarily consented to participate in the study after having received a brief explanation of the general aims of the research. Confidentiality was maintained by changing participants' names and identifying details in all of the reports. In analysing and presenting the data, the anonymity of the participants was strictly protected. The results of the study were shared with the participants.

Data analysis

Content analysis was conducted as follows. First, recordings were transcribed. Each author read each of the transcripts of each of the three groups. After identifying the participants' voices on the recordings, they examined the main units of meaning in each of the individuals' narratives in each of the groups (Patton, 1990; Unrau and Coleman, 1997). Finally, each of the authors integrated the units into main themes after careful examination and re-examination of the texts. Subsequently, the authors compared their individual analyses, discussed differences and looked for areas of agreement. The comparisons related both to the content of the themes and the interpretations of their meaning. The authors arrived at similar interpretations of most of the themes. However, in those cases in which a few themes were identified by only one researcher, the authors engaged in an open discussion and determined whether these themes would be new themes or whether they would be incorporated into other, already existing ones.

Findings
The intervention process

The trauma workers who participated in our study expressed a high level of awareness of the consequences of the STR on their work. In the focus

groups, they related to several issues concerning the methods of intervention, the intervention setting, and the relationship between workers and clients.

Methods of intervention

The STR required workers to demonstrate flexibility and creativity in developing and using methods and means of intervention that were efficient and adaptive to the situation. According to the participants, the past decade has been characterised by a continuous search for such means of intervention. Many participants reported experiencing a shift in their professional approach, from a verbal psychodynamic orientation to bio-psycho-social interventions, and particularly cognitive–behavioural methods. Accordingly, common methods of intervention reported in this study involved cognitive–behavioural (CBT) and body–mind elements. The participants further stated that the process of search and reconstruction of their conceptual framework and the intervention methods they used were chosen according to the successful use of a specific method which had regulated their own anxiety first; they then applied it to their clients.

The setting

Emergency situations disrupt the routine work that takes place between worker and client, and the boundaries between the therapeutic space and the outside world are breached and blurred. In this study, such breaches in the setting were demonstrated when regularity of meetings was disrupted by real-life events, and when the intervention took place outside of the clinic in different settings such as destroyed or partially destroyed homes, or disaster sites. One of the participants spoke about her experience of visiting a client's house immediately following a direct missile hit on it:

> I received a call in the middle of the night and I rushed to my client's house. A missile fragment was stuck in the ceiling right above her bed. I will never forget the sight of the open ceiling, the missiles' fragments, and the missile beyond her bedroom wall. There were many reporters and a big mess in her bedroom so we had to move her out of there. In a more private place we worked this through using breathing and different relaxation techniques learned during our sessions. Then she was able to relax (CP1, woman, senior psychologist).

The breach in the physical dimensions of the setting, namely time and space, led to a blurring of the intra-psychic boundaries between the personal and professional domains. Study participants reported emergency calls infiltrating their personal world at all times of the day and night: weekdays, weekends and holidays. Such calls required a major adjustment on their part, as well as on the part of their entire family. Moreover, it seems that the participants had internalised a moral imperative to their community, even when they were 'off

duty' to the extent that at times they felt they were completely abandoning their personal boundaries:

> During one of my workouts in the gym, a siren sounded and we could hear multiple missiles exploding around us. I found myself conducting an emergency intervention for a stressed student whom I didn't even know. While doing so, I said to myself: you are not at work, this should be your time off, what is your leisure time if you feel responsible for tending to a complete stranger who just happens to be in your midst? (SW1, woman, senior social worker)

Breaches in the setting were also demonstrated in reverse: when 'the outside reality' infiltrated the intervention space. This rupture occurred whenever the regularity of meetings was disturbed as a result of terror-related events: escalations in the conflict, prominent media reports and—most dramatically—sirens sounding during the time of the actual sessions. In such cases, sessions were interrupted, and both trauma worker and client were forced to leave the office. Rushing together to the centre's communal shelter, the client's sense of privacy, trust and safety within the intervention process—and, sometimes, the therapeutic relationship itself—were compromised. Some clients were so unsettled and discomfited by these disruptions that they chose to remain where they were despite the danger.

Breaches between the intervention space and the outside world also existed on a cognitive–emotional level. Participants reported difficulties in focusing their full attention on their clients during sessions, as their thoughts often shifted to the well-being of their loved ones. Conversely, participants also reported thinking extensively about their clients while they were at home with their families, and some reported intrusive vivid imagery of clinical materials. One of the participants said: 'I felt something within me, in my own anxious anticipation in these seconds, which seemed connected to the experiences of my clients. The way they described the senses, sights, sounds and smells became vivid in my mind.'

It seems that the STR led to relatively high levels of identification between clients and trauma workers—something which was observable throughout several stages of the intervention process.

The intervention space

According to the study participants, the impingement of the harsh realities of the outside world on the intervention process both diminished and created opportunities for growth. Elevated levels of anxiety were underscored as a major diminution factor as the outside reality strongly disrupted transitional phenomena including transitional space (Winnicott, 1971):

> One of the most difficult experiences for me as a social worker is the diminished play. The potential space is deeply threatened when an alert is sounded and missiles explode. Concreteness takes over and there is no room left for imagination and symbolism (SW2, man, senior social worker).

Alongside the above observation, some participants reported that the infiltration of reality into the intervention space also provided opportunities and, in some cases, even served to facilitate and promote the process. For instance, one client continually denied her severe reactions to the missile alerts until an alert actually went off during a session; it was only following this incident that she was willing to acknowledge her fears and begin to practise self-regulation techniques.

Trauma worker–client relationship

Deepened identification

A deep identification with their clients yielded positive outcomes, such as a strong therapeutic alliance and sense of sharing; some even said that they were now able to understand their clients 'on a bodily level'. The testimony of one participant who had herself experienced a direct missile hit on her house and who experienced post-traumatic symptoms for some time is illuminating: 'I deeply understand the people who come to us expressing anxiety because I have been through the same trauma' (SW3, woman, senior social worker).

Some participants believed their deep understanding and empathy were invaluable in the eyes of the clients and crucial in promoting the interventions.

However, the strong identification between trauma workers and clients may also have had an effect on assessment, judgement and decision making in different stages of the interventions.

Complexity during different stages of the interventions

For some participants, the mere thought of taking on a case which would evoke high levels of identification with a client seemed too threatening. One participant (CP1, clinical psychologist) stated that for years she turned down adolescents referred to her as they evoked thoughts and worries about her own daughter. Another (CP2) said that, shortly after returning to work following her maternity leave, she found it extremely difficult to initiate parent instruction meetings with a client whose baby had died due to a missile attack. In retrospect, the participant explained that meeting this client would have forced her to deal with her worst nightmares—something she could not bear doing.

During clients' intake and psycho-social assessment periods, the participants were already asking themselves significant questions regarding the extent to which their experience with traumatic reality influenced their clinical perspectives. They were preoccupied with questions such as: To what extent is my assessment of a client focused around the client's exposure to trauma? Shouldn't I, instead, integrate a wider developmental perspective as I would ordinarily do? Am I able to objectively and professionally separate

my own personal experience from that of my clients? Most of the participants indicated that, despite their desire, experience and professional knowledge, this detachment was difficult—if not impossible—to achieve. Some even stated that it was their clinical observation that the clients' distress was nearly always related to the traumatic reality and in fact, even when the clients themselves were not aware of what their distress was related to, they, as professionals, would intertwine it in the evaluation and intervention process:

> Even if people come to me for a different reason, the first thing I ask them is how they feel about where they are living, how they feel about the threat that surrounds them, how they react to the sound of a siren. It's something you have to talk about (SW4, woman, senior social worker).

Another participant (SW5, woman, social worker) adds: 'In many instances, and even if the parents are not aware of it, I find that a careful intake will demonstrate the relationship between the child's symptoms and the missile threats.'

A clinical psychologist (CP2) who had just arrived in the region was the one to suggest that this perspective might be too narrow:

> There is too much emphasis on trauma, and that narrows possibilities. I started meeting with patients, and I could hear their trauma. But I was also able to hear other things. Now I'm preoccupied with this question: To what extent has the trauma taken over, and to what extent does it dominate my mind? What is the trauma worker looking for, and how does that affect what he or she hears?

Others expressed awareness of the complexity, suggesting that both perspectives should be accounted for. However, in some cases, the participants' views were so strongly affected by their own experiences that they questioned their ability to 'move back and forth' from a trauma viewpoint to a wider developmental perspective; some even found it hard to imagine that recovery for their clients was a possibility. As one of the participants (SW5, woman, social worker) said: 'We've worked for decades, but whenever I sense progress . . . the military conflict escalates and my client regresses.' A colleague adds: 'There is never any *real* tranquillity.'

Self-disclosure

When shared traumatic realities are continuous, the common experience shared by clients and trauma workers can become perceptible even during sessions. Some participants felt themselves being carefully studied by their clients, and they expressed the feelings they had about this scrutiny. Some (SW6, woman, senior social worker) reported a feeling of shame when their own fears and startled responses became apparent to their clients:

> It was a major concern of mine. I worried about what would happen during the moment I was exposed, and wondered if I could function as expected of me or

> whether I would lose control and become helpless. I kept thinking of what might happen to me and how my patients would react.

Some spoke of their parental role as moderators of the outside events and felt a great deal of responsibility towards their clients for the consequences of their personal reactions. As one participant (CP2) conducting a family therapy session said: 'I startled at the sound of the bang but immediately realized that three pairs of eyes were upon me and that these clients would react in accordance with my reaction.'

Another participant who did not feel afraid herself was concerned by the effect such a disclosure would have on her client. 'One of my clients, who was highly anxious, asked me how I was doing now that the missiles were directed at my settlement . . . I was not sure how to respond, what her needs were at that moment' (EP1, woman, educational psychologist).

The participants also expressed feelings about their clients valuing the fact that they shared similar experiences. They quoted clients who expressed this sentiment during a meeting: '. . . "outsiders" could never understand us.' The participants sensed that their mutual experiences earned them high levels of trust and intimacy, which made a positive contribution to the progress of the intervention.

Sense of professional competence and growth

Despite the long-term continuous threat under which the study participants in all three focus groups lived and worked, they demonstrated a strong sense of professional competence and growth. Most of them felt they were able to deal efficiently with both the personal and professional demands placed on them following years of working in a situation of STR. They further expressed pride in this resilience and in their staff's ability to succeed and meet all professional objectives and expectations:

> I stretched myself to the limit, as did all of my colleagues here. We were therefore able to enjoy success and pride in our work rather than falling apart. And these are situations in which breaking down is a distinct possibility (SW7, woman, senior social worker).

The participants in our study mentioned several factors that served to promote their sense of professional competence and resiliency. Among these were personal resources, belief in God, optimism and sports, as well as self-regulating techniques that they used in their work with clients. However, several particular aspects were central in all three study groups: first and foremost was the group cohesion within the resilience centres and the strong personal relations that developed between staff members. Most dominant was the participants' sense that they were 'seen' and cared for by their colleagues and by their professional supervisors and director. They felt that both their emotional and instrumental needs were provided for. They underscored the unique conditions and challenges that their work in

the south-west of Israel involved and noted that these challenges distinguished their teams from other teams of mental health professionals in other parts of Israel or the world in general. Staff members felt a built-in connectedness to one another due to shared organisational histories comprised of emergency and life-threatening experiences.

The centres' directors were on the receiving end of profound appreciation. Many of the participants used the term 'parental regulation' to describe what their directors offered them:

> We tend to say that children's reaction to threat is related to their parents' reactions... I sensed this in our staff here. Our director is our regulator .... Knowing that the person in charge was on top of things and would not lose control and ask all of us to report for duty whenever an emergency occurred gave me a deep sense of security (SW3, woman, social worker).

The participants further regarded the knowledge and intervention skills they acquired and developed in their shared trauma work—and which are unique to the continuous threat situation—as facilitating their resilience and sense of efficacy: 'The knowledge we acquired enabled us to work and achieve success as well as promoting our sense of pride in our unit.'

Many participants mentioned their deep commitment to the work they were doing. The meaning they attributed to it derived in part from the help and support provided by their family members and neighbours, who often stepped in to take over the parenting role when their work responsibilities took them away from home—an acknowledgement of the importance of the work they were doing. One social worker (SW7) described how she proudly explained the value of her work to her daughter after her daughter had burst into tears out of fear for her mother's safety.

Discussion

The findings of this study underscore the dialectic nature of trauma work in a continuous STR, as it presents both the benefits and costs of such work. One central finding in our study, which is in line with the literature focusing on shared traumatic realities, was a disturbance in the well-established settings and boundaries that are essential to every intervention. These breaches threatened the sense of coherence, security and trust in the intervention process, and the relationships between trauma workers and clients. Furthermore, the physical aspects of the setting play a role in protecting the trauma workers both from the heavy emotional load expressed during sessions and from the blurring of intra-psychic boundaries between the personal and professional which protect them from becoming more vulnerable to secondary traumatisation (Lahad, 2000). However, the participants in this study were able to underscore the benefits of these breaches and ambiguity when they served to promote and accelerate therapeutic interventions.

The blurring of boundaries was also expressed on a mental–emotional dimension. The trauma workers had reported difficulty in their ability to provide clients with their full attention, as worries about their families and loved ones interrupted them during sessions; however, the continuous nature of the exposure provided them time and space for formally and informally discussing these instances. These discussions assisted in normalising boundary difficulties and reducing the sense of guilt and lowered professional self-esteem which sometimes emerged in the wake of professional lapses (Tosone *et al.*, 2012).

The participants also reported that intrusive thoughts and worries about their clients infiltrated their personal lives and space—one of the symptoms of secondary traumatisation (Figley, 1995). Trauma workers' direct exposure clearly does not eliminate their vulnerability to secondary traumatisation; rather, it places them at greater risk for emotional distress and lends support to the concept of STR, which considers the co-existence of both types of exposures.

In a STR, trauma workers are deprived of the professional distance usually afforded them. Interestingly, in the current study, participants regarded the deep identification with their clients as two-sided. On the one hand, they found that it promoted a sense of unity and created deep bonds within the dyad, which enhanced the client's trust and facilitated the intervention process. However, they were also aware that the deep sense of identification had, at times, clouded their own clinical judgement. The findings suggest, for example, that the deep identification between trauma worker and client brought forth anxieties so painful that in some cases they turned down certain clients or populations at referral, underscoring the importance of personal and peer supervision in such situations (see also Tosone *et al.*, 2012).

The participants awarded great importance to the continuous exposure when referring to different stages of the psycho-social evaluation. Some postulated that, at referral stage, most of the clients' complaints, independently of their nature, should primarily be looked at in connection with the exposure. Others even suggested that, within the given situation, it was actually impossible to achieve any substantial relief of symptoms, as there would always be regression associated with escalations in the military situation. It is not clear whether these views reflected the deep professional understanding and experience of the trauma workers, or whether they were in fact indicators of the pathogenic effects of the exposure (direct and indirect) on the workers' world assumption, future orientation, depression and professional self-esteem—all of which, as mentioned above, may be symptoms of exposure to trauma, psychological burnout and secondary traumatisation (Maslach and Leiter, 1997; McCann and Pearlman, 1990; Janoff-Bulman, 1989).

Despite their extensive personal exposure, the participants' own personal anxieties took a back seat in the course of the focus groups. This finding was in contradiction with the existing literature. One example, from a study conducted among Israeli clinicians following the second Lebanon war (Cohen

et al., 2015), found that 25 per cent of the therapists in the study reported on anxieties related to their own personal exposure (both during work hours and during leisure time) and concerns about their ability to contain their clients' anxiety while preoccupied with their own.

There may be several ways to explain this finding. First, it is possible that the use of focus groups in this study and the presence of the authors—an 'alien' body—may have led to concealment of several issues, among them the sense of anxiety and its effects on the therapeutic space and bond. Two additional explanations could be related to the continuous nature of exposure. Chronic situations can, in the long run, lead to habituation and to the development of effective means of coping that are adapted to the specific situation and moderate the pathogenic effects of exposure to terror (Bleich *et al.*, 2006). Furthermore, repression, which is regarded as useful in some cases, could be one of these coping mechanisms (Weinberger *et al.*, 1979; Solomon *et al.*, 2007).

This explanation may be valid, considering the resilience and high professional competence expressed by the participants in this study. This finding contradicts those in the existing literature, which suggest a diminished sense of professional efficacy and functioning among therapists in a STR (i.e. Batten and Orsillo, 2002; Eidelson *et al.*, 2003). Most trauma workers in our study worked steadily and consistently with clients despite distressing episodes and escalations in the military conflict. They were able to meet high professional standards and expectations, and they continued to develop professionally, learning and conducting therapeutic methods adapted to the continuous exposure.

Several additional variables were found to contribute to the participants' sense of efficacy and resilience in our study. The first was the creativity and flexibility they expressed in their work and the manner in which they viewed the changes necessitated by the STR in their working methods. Viewing this process as a challenging search that led to professional development, they pointed with pride to the new and unique body of knowledge and practical implications they developed.

The participants greatly valued the group cohesion that developed within the working teams and discussed its contribution to their resilience and sense of efficacy. The team cohesion was expressed in the trauma workers' strong personal relationships with one another, a sense of belonging, and in the recognition and acknowledgement of team members' shared life-threatening experiences (i.e. Oliver *et al.*, 1999; Solomon and Mikulincer, 1990).

Participants also acknowledged the crucial role played by their directors and supervisors who, as 'parenting' figures, offered emotional support and regulation. Previous research has also pointed to the need for 'holding' during times of trauma and emergency (Stevenson *et al.*, 2011; Tosone *et al.*, 2010) and points to a relationship between supervisors' support and a strong sense of growth and a low level of distress among social workers in a STR (Baum and Ramon, 2010). The directors in our study also played an

important role in regulating the emotional and instrumental pressures brought to bear on the workers and helped them to manage their conflicting obligations to work and home and the sense of guilt associated with such conflicts.

The findings reveal the dialectic nature of post-traumatic distress existing alongside resilience and a sense of professional competence. These findings are in tandem with Tedeschi and Calhoun's (1996) notion of the correlation between post-traumatic distress and post-traumatic growth. It is possible to see how the participants demonstrate professional growth in the face of the many challenges presented by a continuous STR situation. Unlike with time-limited traumatic events, trauma workers cannot aim to recover past constructs of therapeutic interventions or perform them in chaotic and uncertain environments. They are therefore bound to take on new concepts, ethics and methods of intervention that will sustain them over time. Some participants regarded this as an opportunity.

The current study does have several limitations, however. While the focus group space may have provided a therapeutic means to normalise therapists' reactions (Kitzinger, 1995), it could have also curbed participants' willingness to openly discuss difficulties.

Also, the relatively small number of participants may not accurately reflect the bigger picture. A greater number of participants and differentiation between social workers and other trauma workers could further enable evaluating different groups according to place of residence, seniority, discipline, etc. In addition, an effort should be made to approach these same trauma workers longitudinally, in order to better understand the effects of the chronic, ongoing STR.

Despite these limitations, the study provided an additional opportunity to process participant narratives and reveal several common themes that underscore the concept of 'Shared Traumatic Reality'. By looking at and confronting the challenges which are commonly faced by social workers and other trauma workers in the area, the populations who are on the receiving end of their interventions are also beneficiaries.

Over the last decade, social work practice has widened and broadened as social workers have taken up posts in a variety of settings and sectors which demand new knowledge and skill sets (Joseph and Murphy, 2014). As trauma work cuts across a wide range of contexts and client groups, it must become a core component of education and training in social work. This study contributes to the development of this topic by shedding light on the complicated and demanding work done by trauma workers—mainly social workers—in the southern part of Israel.

The findings of the study further stress the importance of organisational and familial structures as coping resources for trauma workers in an ongoing STR and to implement policies that will help the workers and their families to function. The importance of providing support for supervisors and unit directors cannot be underestimated, and the value of the new body of knowledge

and professional practice evolving among the trauma workers in this area must be acknowledged. In addition, the findings indicate that the trauma workers must be well trained to work in a STR situation and that senior trauma workers, mainly from the region, should be actively involved. The formation of multidisciplinary teams should also be encouraged.

References

Batten, S. V. and Orsillo, S. M. (2002) 'Therapist reactions in the context of collective trauma', *Behavioral Therapist*, **25**, pp. 36–40.

Baum, N. (2010) 'Shared traumatic reality in communal disasters: Toward a conceptualization', *Psychotherapy: Theory, Research, Practice and Training*, **47**, pp. 249–59.

Baum, N. (2012a) *The Role of Social Workers during War Research Report*, Jerusalem, Ministry of Welfare (in Hebrew).

Baum, N. (2012b) 'Trap of conflicting needs: Helping professionals in the wake of shared traumatic reality', *Clinical Social Work*, **40**, pp. 37–45.

Baum, N. and Ramon, S. (2010) 'Professional growth in turbulent times: An impact of political violence on social work practice in Israel', *Journal of Social Work*, **10**(2), pp. 139–56.

Besser, A., Neria, Y. and Haynes, M. (2009) 'Adult attachment, perceived stress, and PTSD among civilians exposed to ongoing terrorist attacks in southern Israel', *Personality and Individual Differences*, **47**, pp. 851–7.

Bleich, A., Gelkopf, M., Melamed, Y. and Solomon, Z. (2006) 'Mental health and resiliency following 44 months of terrorism: A survey of an Israeli national representative sample', *BMC Medicine*, **4**(1), p. 21.

Cohen, E., Roer-Strier, D., Menachem, M., Fingher-Amitai, S. and Israeli, N. (2015) '"Common-fate": Therapists' benefits and perils in conducting child therapy following the shared traumatic reality of war', *Clinical Social Work Journal*, **43**, pp. 77–88.

Cohen, K. and Collens, P. (2013) 'The impact of trauma work on trauma workers: A meta-synthesis on vicarious trauma and vicarious posttraumatic growth', *Psychological Trauma: Theory, Research, Practice, and Policy*, **5**(6), pp. 570–80.

Cohen, M., Gagin, R. and Peled-Avram, M. (2006) 'Multiple terrorist attacks: Compassion fatigue in Israeli social workers', *Traumatology*, **12**, pp. 293–301.

Dekel, R. and Baum, N. (2010) 'Intervention in a shared traumatic reality: A new challenge for social workers', *British Journal of Social Work*, **40**, pp. 1927–44.

Diamond, G. M., Lipsitz, J. D., Fajerman, Z. and Rozenblat, O. (2010) 'Ongoing Traumatic Stress Response (OTSR) in Sderot, Israel', *Professional Psychology: Research and Practice*, **41**(1), pp. 19–25.

Eidelson, R. J., D'Alessio, G. R. and Eidelson, J. I. (2003) 'The impact of September 11 on psychologists', *Professional Psychology: Research and Practice*, **34**, pp. 144–50.

Figley, C. R. (1995) *'Compassion fatigue as secondary traumatic stress disorder: An overview'*, in C. R. Figley (ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, New York, Brunner/Mazel.

Janoff-Bulman, R. (1989) 'Assumptive worlds and the stress of traumatic events: Applications of the schema construct', *Social Cognition*, **7**, pp. 113–36.

Joseph, S. and Murphy, D. (2014) 'Trauma: A unifying concept for social work', *British Journal of Social Work*, **44**(5), pp. 1094–1109.

Kitzinger, J. (1995) 'Qualitative research: Introducing focus groups', *British Medical Journal*, **311**, pp. 299–302.

Krug, R. S., Nixon, S. J. and Vincent, R. (1996) 'Psychological response to the Oklahoma City bombing', *Journal of Clinical Psychology*, **52**(1), pp. 103–5.

Lahad, M. (2000) 'Darkness over the abyss', *Traumatology*, **6**, pp. 273–93.

Lev-Wiesel, R., Goldblatt, H., Eisikovits, Z. and Admi, H. (2009) 'Growth in the shadow of war: The case of social workers and nurses working in a shared war reality', *British Journal of Social Work*, **39**(6), pp. 1154–74.

Maslach, C. and Leiter, D. (1997) *The Truth about Burnout*, New York, John Wiley & Sons, Inc.

McCann, L. and Pearlman, L. A. (1990) 'Vicarious traumatization: A framework for understanding the psychological effects of working with victims', *Journal of Traumatic Stress*, **3**, pp. 131–49.

Nuttman-Shwartz, O. and Dekel, R. (2009) 'Challenges for students working in a shared traumatic reality', *British Journal of Social Work*, **39**(3), pp. 522–38.

Oliver, L., Harman, J., Hoover, E., Hayes, S. and Pandhi, N. (1999) 'A quantitative integration of the military cohesion literature', *Military Psychology*, **11**, pp. 57–83.

Patton, M. Q. (1990) *Qualitative Evaluation and Research Methods*, Newbury Park, CA, Sage.

Saakvitne, K. (2002) 'Shared trauma: The therapist's increased vulnerability', *Psychoanalytic Dialogues*, **12**(3), pp. 443–50.

Seeley, K. (2003) 'The psychotherapy of trauma and the trauma of psychotherapy: Talking to therapists about 9–11', available online at *www.coi.columbia.edu/pdf/seeley_pot. pdf*.

Shamai, M. (2005) 'Personal experience in professional narratives: The role of helpers' families in their work with terror victims', *Family Process*, **44**, pp. 203–15.

Solomon, Z. and Mikulincer, M. (1990) 'Life events and combat related posttraumatic stress disorder: The intervening role of locus of control and social support', *Military Psychology*, **2**, pp. 241–56.

Solomon, Z., Berger, R. and Ginzburg, K. (2007) 'Adjustment of Israeli body handlers: The implications of repressive coping style', *Traumatology*, **13**(4), pp. 64–74.

Somer, E., Buchbinder, E., Peled-Avram, M. and Ben-Yizhack, Y. (2004) 'The stress and coping of Israeli emergency room social workers following terrorist attacks', *Qualitative Health Research*, **14**, pp. 1077–93.

Stevenson, A. D., Phillips, C. B. and Anderson, K. J. (2011) 'Resilience among doctors who work in challenging areas', *British Journal of General Practice*, **61**, pp. 404–10.

Strier, R. (2007) 'Anti-oppressive research in social work: A preliminary definition', *British Journal of Social Work*, **37**(5), pp. 857–71.

Tedeschi, R. and Calhoun, L. (1996) 'The posttraumatic growth inventory: Measuring the positive legacy of trauma', *Journal of Traumatic Stress*, **9**, pp. 455–71.

Tosone, C., Lee, M., Bialkin, L., Martinez, A., Campbell, M. and Martinez, M. (2003) 'Shared trauma: Group reflections on the September 11th disaster', *Psychoanalytic Social Work*, **10**, pp. 57–77.

Tosone, C., McTighe, J. P., Bauwens, J. and Naturale, A. (2011) 'Shared traumatic stress and the long-term impact of 9/11 on Manhattan clinicians', *Journal of Traumatic Stress*, **24**, pp. 546–52.

Tosone, C., Minami, T., Bettmann, J. and Jasperson, R. (2010) 'New York City social workers after 9/11: Their attachment, resiliency, and compassion fatigue', *International Journal of Emergency Mental Health*, **12**, pp. 103–16.

Tosone, C., Nuttman-Shwartz, O. and Stephens, T. (2012) 'Shared trauma: When the professional is personal', *Clinical Journal of Social Work*, **40**(2), pp. 231–9.

Unrau, Y. and Coleman, H. (1997) 'Qualitative data analysis', in M. Grinnell (ed.), *Social Work Research and Evaluation: Quantitative and Qualitative Approaches*, Itasca, IL, Peacock.

Wee, D. and Myers, D. (2002) 'Response of mental health workers following disaster: The Oklahoma City bombing', in C. R. Figley (ed.), *Treating Compassion Fatigue*, New York, Brunner/Rutledge.

Weinberger, D., Schwartz, G. and Davidson, R. (1979) 'Low-anxious, high anxious and repressive coping style: Psychometric pattern and behavioral and physiological responses to stress', *Journal of Abnormal Psychology*, **88**, pp. 369–80.

Winnicott, D. (1971) *Playing and Reality*, New York, Penguin Books.