PSYC 8344
Interventions I
Week 11 – Crisis Intervention

[MUSIC PLAYING]

NARRATOR: Trauma may occur at any time and without warning. In this video program, Dr. Priscilla Dass-Brailsford explains ways psychotherapists can empower clients suffering from crisis situations.

PRISCILLA DASS-BRAILSFORD: Crises are events or situations, which are perceived as unbearably difficult and exceed an individual's available resources and ability to cope. Crises usually overwhelm the person's usual coping strategies, so that they are unable to just carry out their daily tasks, and they find it impossible to conduct their daily business.

There are many different examples of a crisis; for example, someone who's suicidal may find themselves in a crisis. Someone who loses someone close to them-- like a significant other, a parent, a brother, a sister, a child-- will find themselves in a crisis. People who are in automobile accidents will find themselves in a crisis. People who experience a rape or an assault will label that a crisis event.

There are different phases of a crisis reaction: an acute phase, an outward adjustment phase, and an integration phase. In the acute phase, people will find themselves experiencing many different reactions, which I will talk about a little later. In the outward adjustment phase is when they try to pull themselves together and to function OK and to just continue with their daily functioning. The integration phase is what applies to counselors, because it's during that phase of a person's time that we actually work through the trauma of the crisis and put it together.

There are several common reactions to crisis and to trauma, and they fall into five different areas. And I'm going to talk about each area in a few minutes, but I want to make it clear that I'm using the word "reactions and responses," and not "symptoms," because when someone is in a crisis situation, they are usually reacting to an abnormal event. So something bad happened to them, and they're reacting to it. And that's why we call it reactions and not symptoms, because symptoms can be pathological.

So the first area, the first cluster that I wanted to talk about, are the physical responses. And physical responses, as the word indicates, are the responses that you would find in your body, basically. So, people will notice change in their sleep patterns. They'll notice changes in their breathing. They may report having headaches, stomachaches, queasiness, chest aches, hyperventilation. Change in appetite is another physical

reaction; muscle tension, sweating, nightmares, and so on. These are very common physical reactions.

The next cluster of reactions are the emotional reactions, or the psychological reactions. And as the word indicates, these are reactions that you feel. So people might report feeling anger, guilt, shock, frustration, powerlessness. They may also report feeling like they're on an emotional roller coaster, meaning that they may feel up one day and down the next. These are very normal reactions to a crisis.

So the next cluster of reactions that people in a crisis may experience are the cognitive reactions. And the cognitive reactions, as the word indicates, are the reactions that people actually feel in their heads, in their thought processes. So they may feel confusion. They may have slowed thinking. They may experience distorted thinking. They may experience the world as unsafe. They may report having too many thoughts at once. Intrusive images, flashbacks, and so on are very common cognitive reactions.

The next set of reactions are the behavioral responses. Behavioral responses are basically the way people relate to each other. So people may find that they actually withdraw from other people. They want to be on their own. They may report feeling irritable. They may report having difficulty trusting others. They may have an inability to just relate to other people, like feeling very snappy and on a short fuse. Other behavioral responses that counselors should be really aware of is increased use of alcohol and medications in order to cope. And also, when people alienate themselves from their friends and their families, it can become really dangerous, because you won't know how serious the issue might be with someone.

The final cluster of responses or reactions lie in the spiritual arena, where people may begin to have a loss of faith or spiritual doubts. They begin to question their old beliefs. Their belief in their spirituality or religiosity becomes questionable. They find life meaningless. They withdraw from their church or their community. And they have a sense of the world being really changed for them.

So, next let's look at the factors that affect recovery. And there are several factors that affect recovery from crisis events. The first are the trigger events. Occurrences that trigger memories of an event or other losses will affect the way a person recovers. So, if this is the first time, for example, that someone is going through a crisis, they will respond to it very differently from those who have had crises occur in the past.

The second assault I call the media and the court appearances. So, someone may get over a crisis, but then, the media may come along and try to do some reporting on the crisis, or for a rape victim, for example, she may be called into court to make an appearance, and suddenly the person might find themselves going through the crisis all over again.

The duration and intensity of the crisis influences a person's individual responses to the event, as well. So hurricane Katrina, for example, was a crisis of a long duration. Usually disasters, hurricanes, only last for a year, but as we know, people who have been survivors of hurricane Katrina have found themselves in a crisis for a very, very long time. So of course, their recovery is going to be severely handicapped, because the crisis has gone on for so long.

The event itself and the person's relationship to the event; so the closer someone is to a crisis event, of course, the more they will be affected. The further away they are, the less they would be affected. So people who were in New York when the 9/11 terrorist attack occurred would find themselves more deeply affected and be harder to recover from the trauma of that crisis.

Also then, the environment that the person is surrounded by affects their recovery. People who have a lot of support-- they have a validating community around them, a community that normalizes the experience-- will of course recover much better than people who do not have support.

Developmental stage is also important. Recent research, for example, has found that older people do much better than younger people after disasters, because they've gone through it before. They've had several experiences of recovering from the crisis of a disaster.

Trauma history affects recovery, meaning prior losses and other traumas. So obviously, people who have had a number of different traumas occur to them in the past will in some ways have coping skills. They'll be able to manage. Whereas people who do not have that will have a really hard time recovering. An example I can give of that is the work that I had done after 9/11 in New York, and worked with a lot of young people who were twenty-something-- their first job in Wall Street and Times Square-- and they had no coping skills. In the debriefings that I did them, they said, "You know, our parents took really good care of us, and we were never in a crisis situation where we needed to cope. So we have no ability to cope with this." So that's an example of a prior loses.

Next, we should go over the principles of crisis reactions. There are many principles that one should keep in mind when responding in a crisis. The first is safety, and basically, physical safety from the perpetrator as well as psychological safety. So this means that, for example, if someone is suicidal, you have to make sure that they don't have access to medication. They don't have access to a weapon. They don't have access to a means to carry out the suicidal intention.

An example I have of this is the work that I did after hurricane Katrina in New Orleans. I was in a shelter just outside Baton Rouge. And there was a police officer who came up to be sheltered at the place that I was working at, and he hadn't slept for a week. He was basically working in New Orleans for a week, and hadn't slept, and was feeling very

suicidal. And one of my colleagues was working with him because I was busy with someone else, but as soon as I was done, the National Guard person came over to me and said I should come and help with this police officer, because my colleague didn't seem to be getting anywhere.

And the first thing I noticed with this police officer was that he was fully armed. He had a gun. And so I went over to his other colleagues, other police officers, and told them that the first thing that needs to be done in this case is to disarm the police officer. And they told me, "Of course we can't do that, because he's a police officer, and you can't take the weapon away from him with his uniform on." Then I said, "Well, get his uniform off." And so they worked on that, and they got his uniform off, and they took away his gun. And he was in plain clothes after that, and I was able to work with him. But the point to the story is that we removed his access to killing himself. And a few days later, he was doing much better, after some sleep.

Venting and validating is a really important principle in crisis reactions. So giving people an opportunity to just talk over and over again about what's happened to them will help them normalize their reactions. It also helps tolerate contradictions, the tension they may feel, and the confusion. And people may just find the need. It's like a broken record. They may have to say something over and over and over again. In psychology, we use the term "perseveration" to describe this reaction. Also important to validate all reactions of the person who's in crisis and not to question or to contradict any of their reactions, but just allow them to talk about all their reactions in a full way as they need to.

Important to remember that crisis interventions are always short term. So whatever you plan to do to help a person has to be short term, which means that you have to establish specific goals that you hope to achieve in a very short period of time, within a very short term. The idea behind doing this is to manage the crisis reaction, rather than to resolve it. You often want to basically provide people with emotional first aid. You just want to cover things up so that they can go for longer-term care to someone else.

Pshcho-education is really an important principle in working with people in crisis. Basically, this means giving them as much information about their crisis reactions as possible. So letting them know the difference phases that they can expect to go through. The acute phase, the outward adjustment, and the integration phase can be very helpful. Another, if someone has experienced the loss, for example, of someone close to them, going over Elisabeth Kubler-Ross' grieving process. And she has five different stages; can be very helpful. The first stage is denial. The second stage is anger. The third is bargaining. And the fourth is depression. And the final one is acceptance. So, just knowing that there's those different stages that are expected can be very helpful to people going through a crisis.

Also really important is for them to have resources and referrals. So any good crisis intervener actually has a list of different crisis intervention places that people can go to get immediate help. So mental health resources, and so on, where they could probably attend a group, would be good to have that information. What's really important in keeping these resources and referrals is to make sure that the numbers that you provide to these resources actually work, because as you know, when people are in a crisis, they can't remember things, and it can also be very frustrating to call a number that doesn't work. So make sure these resources and referrals are actually operational.

Another principle of crisis intervention-- and this is an important one-- is predicting and preparing. Things change over time for people, and they may think that they have gotten over the crisis. But then the anniversary may come along, and then they find themselves back in square one, almost, and finding they're having the same reactions that they did when they initially went through the crisis. So letting people know that this is very expectable, that even though the reactions may feel the same, they are not the same. And preparing for anniversaries is really important. They may have also developed some good coping skills that they can reach into. And if they have an ongoing counselor, that's someone they can reach out to and get help immediately.

Another important principle of crisis intervention is planning for future needs and safety. So for example, if you are working with a woman who's in crisis over a domestic violence situation, it would be really important to develop a safety plan for her, so that she knows how she can get out of a situation when things becomes really dangerous, that she has resources that she can reach out to, and so on. And basically helping her develop a safety plan is important.

Psychological first aid is another concept that comes up in crisis intervention, and basically, psychological first aid involves establishing rapport with the survivor, gathering information for short time assessment, and providing immediate services. It's facilitating telling of the trauma story and venting feelings as appropriate. So it's another word for a quick fix. Basically, you want to do things as quickly as you can, and allow the crisis survivor to come around as quickly as possible.

The model has four different stages. The pre-intervention stage, this is a very, very important stage of intervention. It's the time when you spend finding out as much as possible about the community or the person that you are going to be working with. You do background information, you find out about resources in the area that you might be intervening in, and so on. And the idea behind doing this preparatory work is that once you get there, there are no surprises. That you feel well-prepared to handle the crisis, because the last thing that a person going through a crisis wants to deal with is their counselor who's in a crisis, trying to find resources, and so on. So the goal behind doing this work, then, is so that you can be very calm and collected and prepared when you interact with the client in crisis.

The next stage is the assessment stage, and this stage has three important objectives. First of all, in doing the assessment, it's really important to assess the person's medical and health functioning. For example, you should know whether the person has diabetes, hypertension, physical injuries, and so on, because it's not worthwhile working with a person's psychological needs if they have more pressing medical and physical needs. So if someone's bleeding, for example, or they have a leg that's broken, that might have to be attended to before you attend to the next stage, which is the psychological functioning area.

And here, you would need to do a quick mental status evaluation and assess for the level of risk to self and others, and other behaviors that could be high risk. For example, if a person reports that they're using substances or using illegal drugs, that's an area of caution. If someone reports feeling suicidal, for example, then that's something that needs to be attended to. So doing a quick mental status is really important. In the mental status, I would also encourage you to ask about their sleeping, their eating, and their level of interest, because those three usually also help in the diagnosis of depression. So those are important.

Assessing the support system, and the belief system, and acculturation level of the person you are working to is really important; knowing their economic resources, whether they have access to family and friends, whether they basically have people around them it's really important.

So in terms of this, what I find really helpful is to construct an ecological chart when I'm working with people in crisis. And basically, the chart is made up of several intervening circles with the person who's in crisis in the middle, and asking them what are the different communities or the different groups you could name around you? And people will name different communities. They might name their family, their friends, their work group, their neighbors, and so on. By using this chart, you'll have an idea on which resources you could probably use with the client in terms of planning for the next step.

Disposition and referral is the next stage of the empowering model. And basically, in disposition and referral, you're now going to send the person on to some other caregiver who will do long-term care with the person. So in disposition and referral, it's important to do psycho-educational, basically giving them information about what's going on with them. Exploring next steps with the client can be very empowering, because you can be using them to resolve their own situation. So asking them what are your needs? What do you think you need to do next in order to get over this? "Have you been through this before" and "how have you been able to get through it," can be very empowering, because you're using the client as a resource.

This is where you give the client the referral and resource list. You give them information about resources written very clearly on a card. And remember, the person is in a crisis, so it's important that they are able to read what's on that piece of paper

that you give them. So it might be helpful to sit with them and read it with them; go over the steps very carefully, so that when they leave the room or they leave the place that they are with you, they have a very clear course of action.

Finally, we can go over other interventions that have been used in a crisis. Debriefings, for example, have been very popular in crisis situations. And just to very quickly tell you, debriefings are single sessions, semi-structured crisis interventions designed to reduce and prevent negative consequences. And basically, what happens in a debriefing is that 8 to 10 people sit together, and these 8 to 10 people all would have gone through the crisis together. And a group leader will review the reactions with them, give them an opportunity to vent and talk about their emotional reactions to processes they experience, and to basically discuss their coping skills. So it's a very quick intervention. It usually takes between 90 minutes to 2 hours to complete.

But it's important to say that debriefings have been very controversial, because some people have found that people in the group setting may not be experiencing severe reactions, and by listening to other people who are experiencing reactions, it may trigger them to feel that maybe they should be feeling reactions. So that's been one major criticism of debriefings.

Other interventions are group interventions, which are useful in educating participants about the process of recovery, reviewing crisis reactions and considering coping responses. And I prefer to use group interventions, because basically, you can pace it according to the needs of the people who are going through the crisis. Also, group interventions foster natural group resilience, because people share with each other different coping mechanisms, and so on. And good group interventions acknowledge a client's strength. It restores control and empowers them to take charge of their lives.

Doing crisis work is very challenging, and it's important to bear that in mind. So the chances of getting secondary trauma or vicarious trauma from listening to very traumatic stories, for example, are very high. Therefore, it's really, really important for people who do crisis work to practice good self-care strategies. And there are many self-care strategies that you probably already have been practicing.

Before getting to those strategies, however, it's important to be aware that you are experiencing reactions to listening to your client's stories. So earlier, I had mentioned all those different reactions that clients go through. As a crisis counselor, you may find yourself experiencing very similar reactions. And if you do, then it means that you need to take care of it.

And there are different ways of taking care of yourself: talking to your supervisor about it is one way, talking to colleagues, other self-care strategies, rest and relaxation, eating healthy food, exercising, doing things that make you feel better, for example, I enjoy

reading. I enjoy going to the movies. I enjoy playing with my cat. Those are things that give me a lot of joy. And that's what helps me cope with doing crisis work.

When working with suicidal clients, there are several important things to remember. You might often find that people will say, "You know, I'm feeling suicidal." And you have to differentiate between whether it's suicidal ideation or they are going to really carry out the plan. And there are ways to assess that.

First of all, to find out whether it's just a thought or whether they have the means to carry it out, whether they've been thinking about how they're going to do it is really important. In assessing, also, with suicidal clients, the ecological chart can be helpful to know what resources they have around them, so that you can reach out to those resources to provide support while the person is going through this very difficult time, this crisis in their life. In terms of means of carrying out the suicidal ideation, asking them, for example, whether they have a gun or whether they have medication? Have they thought through exactly how they're going to carry out the suicide can be useful.

Give you an example. At one time I was working in a work place. They were downsizing, and they had called me in. Workplaces usually call in psychologists when there's a downsizing, because sometimes people take the news very badly. So it's unpredictable about how people are going to react. And the human resources person called me in, because this one gentleman, as soon as they gave him his packet, he said, "OK, so now I can kill myself." And she didn't want to take that lightly, so she called me in. And when I walked in, he at first thought I was the person who was going to give him a job. And I said, "No, I'm just there to talk." And he said, "What's there to talk about?"

So very quickly, I was able to assess that he was feeling very hopeless, which is important. When people are feeling hopeless, they're a high suicide risk. And I said, "Well, you had mentioned harming yourself by taking your life. And he said, "Yeah, that's what I'm going to do, because my family's better off without me." And I said, "How do you mean?" And he said, "Well, they'll at least get insurance, and they'll be better off than having me unemployed."

So I asked him how he thought he was going to carry out his plan, and he said, "Well, when I drive home from work today, I go over a bridge. And there's a huge pillar that I go by, and I'm going to hit that pillar and kill myself." And I said, "Well, what if you hit the pillar, and you just get hurt and you don't die?" And he said, "Well, the speed I'm going to hit that pillar will probably be between 130 to 150 miles an hour. And at that speed, I know that I'm not going to live." So it was very clear to me at that point that he had a very clear plan on how he was going harm himself.

So of course, since it was a work setting and not a hospital setting, we had to call in the police, who were able to do a quick assessment and take him away to an in-patient

setting. And I feel that in that situation, it worked out that a life got saved in some ways, but it was very clear that he was going harm himself.

So talking to a client and assessing whether they have a clear plan can be very helpful in knowing whether they are going to carry it out or not. Because sometimes people just make suicidal statements because they are seeking help. But even if these are made, they should never be disregarded. They should be pursued in a very clear way, so that you feel when the patient or the client leaves you that they are not going to self-harm.

The same also applies to homicidal ideation. If someone mentions that they are going to harm someone-- I'm going to kill this person for what they did to me-- ask them, "Oh, do you have a plan how you're going to do this?" And if they do have a plan, then you might have to report it. Really important, both suicidal and homicidal ideation are reportable events.

NARRATOR: Next, Doctor Rony Berger describes what counselors face when working with veterans returning from combat. He also explains differences between veteran and civilian reactions to trauma.

RONY BERGER: I just talked to a British veteran who came not long ago from Iraq, and one of the things that he described is, he was sitting in the subways, in the Tube in London, and all of a sudden a man of an Arab look came to the train, and he found himself wanting to hit this guy. And he was alarmed by that. Now, here is an example where the survival mode continues. It was three days after he's coming back home. There was no debriefing in between. And he's still in Iraq, partially, because it takes time to go back home.

That's one thing. The other thing is survival mode is an adaptive mode. You need to protect yourself. You need to be very conscious of everything. And it takes time to rewind it. It takes time to go back to normal. Very often, we find veterans who are going back home operating as if the danger is still there.

In Vietnam, very often there were just a few weeks in which the person was in transit back home. In terms of the Israeli Army, there have been debriefings and processes by which veterans come back after they go active duty. The transition is sometimes very short and does not allow the person to go from a survival mode into a civilian mode. My feeling is that we need to find another way to transit people, particularly when they do a tour that is long, like in Iraq, and has been taking them to a different continent, different values, different system, different way of operating, and now they have to go back home to America. My sense is that hasn't been a very productive way of doing it, and my feeling is that we need to do it differently.

First, I think we need to allow a lot more time than it takes today. We need to find ways by which the person will share their experience with their comrades, who seem to be

the only ones who understand them, at least experientially, according to them. Because very often, veterans come from Hell, and they try to explain to people what they've gone through, and find themselves being alienated, because people don't understand them, don't know what they're talking about, don't have the same experience. And it's very, very difficult to share that experience once you're not there.

The other thing that I think is very important is to move from a very physical alert position, that very often veterans are at, into a position where you eventually allow more tolerance, more patience. Another example that another veteran had given me, they were driving on a convoy. And usually when they reached a bridge, they shifted the place that they moved the bridge, because very often, one side of the bridge there was explosive, and they just needed to protect themselves. Now, this guy is telling me he's back at home, and all of a sudden he sees himself in the middle of the street, and automatically on a remote control motion, moves the car to the other side, almost getting into an accident. That example shows you that it really takes time to move back into a civilian mode, if you want.

Now, one other thing that we found out, that we learned from Vietnam, was that many times people, when they reached a disagreement with people at home and at work, overreacted. Now, overreaction in the battlefield is perhaps adaptive. When you see some minor thing and you need to protect yourself, you're going to be shot at, you might as well shoot back. But at home, it's counterproductive. That's why very often, we find out that people find themselves in trouble, having anger outbursts, having marital discord, et cetera.

So back to the preparation, I think it takes a long time to prepare people back home, and we need to give them the chance to do that. Aside of sharing feeling and aside of processing some traumatic experience, I think it's very important to understand that if you're not there a year or a year and a half, people moved and they're in a different place. And I think that somehow people slowly need to find out that their comrades, friends, wives have developed new ways to adapt when you're not around, maybe some roles of yours have been taken by somebody else. Maybe your child doesn't recognize you and doesn't listen to you, because he's used to his mom telling him, or giving him orders, et cetera.

So I think those issues need to be addressed in a slow manner, in a very deliberate manner, so as to allow people to return back to where they came from, and where they came from is never where they left. Things move on in both sides.

Some of the indicators of post-traumatic stress disorder in veterans is the survival mode that I was talking before. How it translates in real reality is that they are very, very tense. They have problem with concentration. They have problem sleeping. And they have problem with taking small cues and translating them into a very strong reaction. If a door slammed, they jump. If somebody makes a small comment, they may see it as an

aggressive thing. We call it "startle response." And all these things about being startled is an indication that the person is in alert mode, and he didn't rewind himself and really start to slow down, calm his body, and become a normal reactor.

Another element that we find in veterans that are coming home that is indicative of problems is numbness and disassociation. It looks like the person is not completely, emotionally there. It's like you talk to them, but they react slowly. There is a sense of cynicism and apathy. It's as if they go through Hell, they've seen everything, and they're not impressed by anything. It's their affect being a little bit curbed, a little bit narrow. And that's a sign that somehow, something got stuck in the person's mind.

The dilemma with that position is that people who are not fully, emotionally there may not be fully, emotionally later on. And we need to return them back to the state where they're at. When they reach that state, very often they might find very strong experiences, horrifying experiences. And then we need to process these experiences. But that's why it's important to notice that. It may be not obvious in the beginning. The person will look as if he's changed, as if he's not the same person. That's an indication that he's being dissociated and disconnected.

Another element and another sign is alienation from other, which translates into, "I don't want to be with another. It's not as important for me to do the same thing with the same people I've been before." This is again a sense of I'm back there, knowing life different, and now I'm here, and this is not connected to me. I'm not interested in these people anymore. Things are meaningless. All of those complaints, all of those problems, indicate that the person that has not entered back where he came from.

I might add two more signs that are even more alarming, and that is that people start to be numb not only emotionally, but medically. They start to medicate themselves in order to avoid some of the horrifying experiences that all of a sudden start to emerge, nightmares, et cetera. And we find them using drugs or alcohol, which are very, very common in veterans that have not processed some of their traumatic experience, and now they're processing it by shutting it down with those self-medication procedures.

Finally, I would say is that violent outburst is another common sign of veterans with PTSD-- which is different from civilian, by the way, because we don't see that much with civilians-- but with combat soldiers, what happens is when they're in their mode of survival, and they're ready to fight, and there is a small cue and they're hyper-alert, all of a sudden they find themselves fighting with people for stupid things; like something in the bar or a car parking. Things of that nature, which become very big all of a sudden, and may get them into trouble, sometimes even trouble with the law.

So those are the complex things that we see as signs of a veteran coming back home.

The first type of intervention that we do, once we are seeing a PTSD or traumatic combat veteran is to realize that they are very ambivalent about coming to us. The two reasons that they're very ambivalent, first, they are not sure that we can understand them. We have not been in the same place. And secondly, their tradition of being macho, fighting, being a man is being compromised by some of the symptoms that they encounter now. So while they may even volunteer to come to us, very often they're ambivalent about that. They're not sure that we can do it.

We need to respect and acknowledge that. And once we do that, and once we listen to them and let them know that it will take time for us to understand what they're going through and that it's very, very difficult to understand the same experience-- perhaps not even possible, but we can empathize with them-- that will be the first stage that I think a therapist needs to be with.

The other thing is, very often, perhaps even before, is the timing. In Israel, for instance, after the Second Lebanon War, we found out that although we advertised our desire to help people, and we know that many people were very, very much traumatized by the very severe consequences of the war, many people didn't want to come. There is a sense of timing that is right. A year later, all of a sudden we see people coming. So what I'm suggesting is that we need to respect the time of people to process their experiences, and to realize that something wrong happened to them.

We need to bear witness. Very often, psychologists don't know what bearing witness means, but it's essentially being respectable, understanding, and allowing them to share their pain with us. That is an important feature. Once you can do that, you can move to the next stage, which is to process their traumatic experience.

We know that post-traumatic stress disorder is about experiences that have not been processed enough. That the memories stay with a person. That he or she acts as if they are still in the battle zone. One way to deal with that is to do processing on four levels. The one level is cognitive-- the storytelling. What happened, how it happened? Fill out gaps, because sometimes memory is funny. We have black holes. We don't remember everything. That's very important, to create a narrative, a logical narrative of what happened.

Secondly emotionally, let the people experience what they may have not allowed themselves to experience during battlefield. It's very hard to see a soldier crying or very angry and shouting, because they are in a certain position. So we need to let them experience their emotional experience.

Third, we need to let them experience their body reaction. That is crucial, as far as I'm concerned, because many people are not in touch with their body. They may have talked about that. They may even have cried a little bit. But they have not been able to allow themselves to feel the tension in their body. So somatic experiencing, which is a

mode of processing feeling in the body. Even exercise, in terms of preparation that might be a useful thing, also. Even doing things with the body, from active playing into relaxation and meditation, all of this package is extremely important for veterans.

And then comes the narrative processing; the force, if you want, way of processing the experience. That is the way, in which you design meaning, construct meaning to the experience. Many people, particularly veterans, find themselves fighting wars that they don't understand why they're fighting, what they're doing there, coming back home, finding the population not supporting them, like in Vietnam, or even negating them; looking at them as murderers, as people who've done horrible things. That kind of sense of betrayal and that kind of meaningless experience they need to frame in a different way.

So part of the therapy is to allow them to understand what they're doing, why they're doing, and either express their content or their disagreement. Now they can do it. In active duty they couldn't, because their comrades and friends were there. Or perhaps find out the honorable way in which they served, the reason they served. Being in touch with this meaning makes the experience meaningful.

And then you can take it and encourage people, facilitate them, go into the community and explain their position and being acknowledged that way. They can go to school, and if they are against war, talk about that, or if they're for war, and talk about that. The individual meaning that the person attributes to his experience is respected, but within that, it will be very helpful if they go to the community and let themselves be known and contribute in that way. Any contribution after trauma makes the trauma experience a lot more meaningful. So, that's part of it.

I think we need to acknowledge the fact that the trauma is very different. Civilian trauma is usually unexpected, uncalled for, meaningless, because it comes out of nowhere; whether it's a terror attack, whether it's a major natural disaster, to war, you go for a reason. To war, you go prepared. To war, you're expected to know what's there. There are unexpected things. The enemy may surprise you. But you're in a mode of being ready. And that is very different, seen all together. That's why; by the way, the prevalence of civilians who are exposed to trauma and develop PTSD is much higher than soldiers. We do have soldiers who develop PTSD. But the number relative to the civilians who experience terrorism or a major disaster, it's much smaller.

In terms of the treatment, I think the shift in civilian trauma is more vast, because what happens when you experience uncontrollable civilian trauma is the changes in the way you see life. From going in the street, or going to Wall Street, all of sudden a wonderful, beautiful, sunny, sky becomes totally uncontrollable, and life becomes dangerous. And other people are suspicious. And yourself, you consider yourself as being vulnerable, and the future is not clear. All those changes in major perception does not happen doing war, because during war, you are able to foresee those coming. You know that the war

is dangerous because you're going to fight. You know that you're vulnerable because you know yourself, but you still may find that you are different in war.

But the difference is that sometimes, during war, you're not able to recognize the fact that the experience itself is meaningless to you. In other words, when you go to war, and you think there is a purpose, and all of a sudden you're there and you don't understand what you're doing there, and you don't feel that the society supports you, and you feel like your opponent politician, you end up being extremely annoyed, if not enraged. And we have a lot of people that are in this position. That is the rage. And the outburst of anger is not typical to what we see as civilian survivors of trauma. They are more anxious. They are more stuck in their experience and not trusting people. They are not like the veterans who are extremely angry in their society, and the politician, or whoever they see as the perpetrator who put them there.

Another feature, and the last one, is that when you go to war, you're both a survivor, but you may be a perpetrator, because you find yourself in a position of killing others. I don't think there is any preparation for that. Even though you can prepare people technically how to do it, the human resilience of killing another person is very difficult to contend with, even if you justify the act. So I think that is a very different kind of traumatic experience. And we know soldiers that, although being prepared, although being justified, when they kill another person, and they look at the person's eyes, and they all of a sudden realize that person has a family and children, they have a very difficult, hard time to contend with. And we need to let them experience that, and express it, and find some content in making peace with that, which is not an easy thing, which is unlike the civilian trauma.

I think the first thing is that you need to be modest, and you need to be able to take in a lot of graphic, horrendous experiences. So in some ways, you need to be immune to listen to stories that would be terrible; body parts, people blown apart, maybe civilians being killed, like in Iraq. And when you are ready to work with people like that, you've got to be yourself ready to take it in, because it's going to impact you. There's no doubt.

You need to also allow yourself to know your own values. It's very important that you know where you stand on the side of war and the reason for the war. Because veterans are extremely sensitive, if they sense that you're not on their side. We know that therapists are very often empathetic, humanistic, and against war, while veterans, not necessarily. So even if you can hide it and you don't express it, they pick it up. So that to me is also very important, that you acknowledge your own values, for war or against war, and that you somehow make peace, and maybe even share it with the person in front of you, and see if they want to work with you.