Chapter 33

From Helplessness to Active Coping in Israel: Psychological First Aid

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(This chapter is part of the book: Transformative Social Work Practice Schott, E. Weiss. E.L. Sage publication)

Chapter Objectives

- Explain the development of perceived trauma;
- Describe concepts of interventions;
- Demonstrate intervention skills;
- Formulate first response intervention protocols.

Case Vignette

It was the third evening of incessant shelling in the southern city of Ofakim, Israel. Most residents were safe in their shelters. I, Shirr, third year social work student, was sitting with my supervisor in the local Psychological First Aid Center (PFAC) when an intensive care ambulance drove up. The doors opened and a young woman, more or less my age, was brought out on a stretcher. She did not speak, nor did she move as the paramedics carried her out. Her eyes were open, but her expression hollow. She was accompanied by her parents. The paramedics reported no physical injury. As she was carried into the PFAC I felt my own pulse accelerate as the adrenaline surged through my body.

She was placed on a chair, lifeless and soulless like a block of wood, disconnected, catatonic and totally dissociated. 'Hello, my name is Shirr, what is your name?' No response. I took her hand and asked that she squeeze it back each time I squeezed hers. On the fifth attempt she responded by squeezing my hand a number of times and then began to communicate verbally, telling us her name is Michelle. "I am with you and you are not alone" I kept assuring her.

At first she gave monosyllabic answers disclosing only a few details about herself. Eventually, she responded in more coherent sentences. We challenged her to stand up and take a few steps with us towards a designated point in the room and back. When she returned to her chair we offered her a choice of soft drinks. She chose water and after the first gulp her face "melted" and her flat affect disappeared. She smiled.

We asked her to describe the events in a chronological order. She was in the car with her mother, when suddenly the air raid siren sounded, she stopped the car on the side of the road, encouraged her mother to step out quickly and they both lay on the ground with hands over their heads. She insists that she saw the missile and at that second she knew that there is nothing she could have done. She felt totally helpless. She heard the very loud boom and all she could remember was the smell of gunpowder and her mother screaming *and the silence following the boom. The next thing she remembered was just now, talking to us.*

Throughout the entire intervention she was dissociative and her progress was very slow. We noted that there were numerous gaps in her story, much displacement and disorder. We questioned her trying to help her reconstruct the missing content of her story and rearrange it chronologically while simultaneously reassessing her condition.

She started walking on her own with little support from us. Throughout the entire time we encouraged her to continue talking and repeat her story adding new information that created a coherent narrative beginning a few minutes before the event and ending in the present. After 30 minutes I noticed that her verbal abilities had improved significantly. She laughed when I joked with her and called me by my name. She was back! I asked her what she felt her level of anxiety was at this moment (1 - low - 10- high), after an intervention of nearly 40 minutes, she answered "3". I asked what she thought her anxiety level was when she arrived at the center. She answered "10". We explained to her what she should expect during the coming days, encouraging her to return to her normal routine and activities.

Introduction: What Makes An Event Traumatic?

Psychosocial responses to traumatic events at the individual and community level have received growing attention in recent years. The role of the mental health practitioner has come to be recognized as an important buffer in the development of PTSD (Rowlands, 2013).

A traumatic event is defined as an experience that causes physical, emotional, psychological distress, or harm. It is an event that is perceived and experienced as a threat to one's personal sense of safety and to the stability of one's world (Bessel et al., 1996). However, individual reactions are diverse. Not all people who experience a potentially traumatic event will perceive the event as traumatic. Perception of such an event is rooted in the individual sense of threat and resulting sense of helplessness (DSM-V, 2013).

Unlike routine life, traumatic or emergency situations are unexpected, unstructured events – an individual does not know where or when they will occur or who will be in need of help. Such a situation demands among other things, instant mental health interventions and adaptation of these interventions to the particular characteristics of the event (Schreiber et al., 2004). "First response" in these situations is of utmost importance: immediate, focused and efficient interventions are beneficial for the reduction of acute stress reactions and a

return to normal functioning as well as decreasing risk for future onset of post-traumatic symptoms (Shapiro, 2012).

It has been estimated by the Israel Home front Command (Colonel A. Bar, personal communication, January 4, 2010) that on the micro and macro levels the ratio between casualties suffering from physical injuries and mental health injuries is 1:4 – 1:8. In other words, for every individual incurring a physical injury 4-8 will suffer from acute anxiety and may develop an Acute Stress Reaction (ASR) (DSM-V, 2013). These figures emphasize the importance of developing a working model by which social work practitioners are trained to provide mental health first aid as early as possible (Cacciatore, 2011). Accordingly, the Israeli welfare system has designated social workers to be the first responders in time of emergencies. Therefore, providing specific training for first responders is crucial. It is important that social workers be equipped not only with basic intervention techniques but also with extensive knowledge of the bio- psycho-social aspects of trauma.

The aim of this chapter is to provide a first response practice model for social workers that equips them with the knowledge base and intervention skills necessary to manage and assist others with traumatic events. This model is based on the broad hands-on experience that social workers in Israel have had over the past two decades intervening in natural disasters and terror attacks. In light of the understanding that while interventions in emergencies are brief, at times lasting only seconds or minutes, their subsequent consequences may reverberate for many years after the event (Herman, 1992).

Micro Perspective

Perceived Psychological Trauma

Assessment in the context of PFA must be a rapid, concise and accurate process. Three major symptom clusters are assessed in clients. The first is of the acute stress reaction, demonstrated by the existence of fear, threat and helplessness. The second is the

therapist's functional assessment of the client: Dependency - motivation to return home, verbal fluency, controlled motor activity, and non-intrusive memories. The third is assessment of the client's hyperactivity related to the sympathetic system: cold sweat, hyper ventilation, hands / legs shaking, increased heart rate, reddish face, and "cold feeling."

When Michelle described the event, she was talking about two major factors that led to her seemingly catatonic reaction: A huge existential threat: She heard and could even see the rocket coming towards her. A total sense of helplessness: She immediately realized that she could do nothing about it.

The combination of these two factors created a sensation of *perceived trauma* (WHO, 1992) marking ten on a scale from 1 (low) to 10 (high), as demonstrated in Figure 1

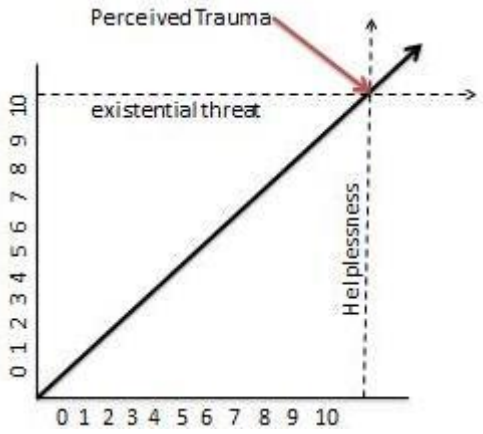


Figure 1. The perceived trauma.

Since threat as well as sense of helplessness is both subjective, every person might experience it differently. An event can be very frightening for one person and be perceived as traumatic but can be no more than a challenging event for another person. Whereas Michelle experienced total helplessness Shirr, not much older than Michelle but in a professional position, when faced with an adverse situation, would react *actively and effectively* rather than helplessly and therefore would not perceive the event as traumatic.

The timetable of perceived trauma. We know when the trauma begins but when will it end? As we have just seen the perceived trauma happens only when helplessness and huge threats join together. Figure 2 demonstrates the timeline of the perceived trauma.

Figure 2. Timetable of perceived trauma.

The neuropsychology of Acute Stress Reaction: The use of cognitive communication. The "Limbic System" controls the autonomous reactions, i.e., those not dictated by cognition and will (e.g., hormonal secretion, accelerated heart rate, increased blood pressure and perspiration, etc.). The limbic system includes the limbic lobe and the amygdala. These are the brain areas that are implicated in the stress response. The amygdala is the integrative center for emotions and motivation. The limbic lobe is responsible for automatic physiological reactions (e.g., blood pressure, heart beat rate and so on) and reactions (defense instincts). The frontal cortex is in charge of our ability to think, choose, prioritize, and make decisions. Yet, hyperactivity of the amygdala leads to hyperactivity of the limbic lobe and for deactivation of the frontal cortex. Deactivation of the frontal cortex results in a significant reduction in our ability to think, make decisions and prioritize (Bremner, 2006). All these lead to a sense of helplessness which is one of the major parameters for perceiving the event as traumatic. Figure 3 describes this process.

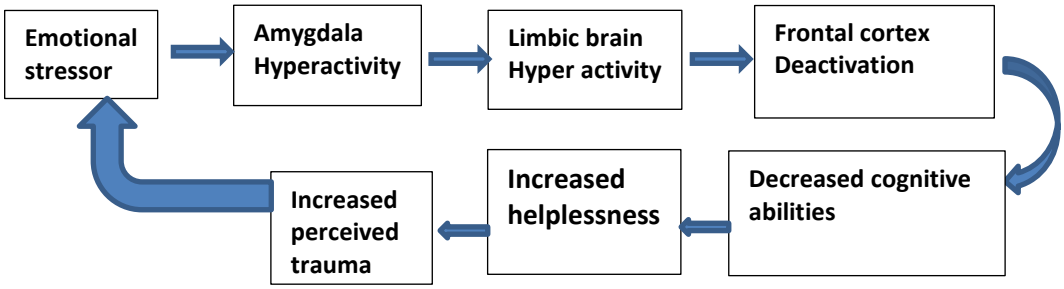


Figure 3. The impact of the emotional stressor on perceived trauma.

The outcome of this process can be surprising for mental health personnel: Using emotional communication channels during the acute phase increases and worsens the perceived trauma and also increases the risk for future Posttraumatic stress disorder (PTSD). This is what Shirr was doing with Michelle, instead of using ventilation with her at an emotional level she used structured cognitive communication aimed to activate Michelle's prefrontal cortex and help her make sense of the event.

The traumatic memory. In the event of a perceived trauma, , our sympathetic system become hyper active, sharpening our senses. As a result, every detail of the event becomes highly significant and is stored in our working memory. Our five senses (sight, smell, taste, touch, and hearing) are transmitting an enormous amount of data over a very short period into our working memory. This overload makes it difficult to differentiate between significant and trivial details confusing the chronological continuum of the event. This continuum is extremely important for defining and experiencing a sense of closure of the event. If the event has no clear conclusion, it will continue and continue, creating nagging, intrusive thoughts that refuse to heal. Michelle could not differentiate between the various details of the event; only after she was able to reconstruct her story from beginning to end did she achieve closure.

Reactions to perceived trauma can be divided into a number of stages:

(1) Acute Stress Reaction (ASR) (0 - 48 hours post event): Occurs when symptoms develop due to a particularly stressful event that may pose a perceived existential threat on one's life

followed by a total sense of helplessness. Since these two factors are subjective, each person might perceive and react differently to the same event:

(2) ASR Symptoms: There are a wide range of symptoms occurring during the acute stress stage (Soldatos et al., 2006). The International Classification of Diseases (ICD-10) describes three major elements which create the ASR: fear, threat and helplessness – all of them must be extreme. These elements cause a chain of reactions. (3) Confusion and disorientation: The “flooding” of information pouring in from all five senses that are "photographing" the event from a variety of angles; causes difficulty in organizing the event’s chronological order making it impossible for the individual to define its beginning, middle and end. (4) Loneliness: helplessness causes the feeling of aloneness. (5) Hysteria: a state of "psychomotoric agitation" is a reaction characterized by extensive ineffective movement and verbal expression. The sympathetic nervous system is in a hyper activation mode increasing pulse, blood pressure and general metabolism. (6) Catatonia: hyper tonus of the muscles (spasm) causes a feeling of "paralysis." The sympathetic system is in a hyperactive mode that increases pulse, blood pressure and general metabolism – but unlike hysteria – this hyperactivity is trapped in a paralyzed hypertensive body. This state can create hyperventilation, confusion and frustration, while cognitive functioning continues. (7) Dissociation: may be expressed in *full dissociation* - aimed to detach the person's consciousness from the actual reality creating a flat affect, with no ability to communicate, and cooperate with others; *partial dissociation* - a state in which the individual is active but partially dissociated. This is characteristic of first responders (physicians/police/firefighters and social workers) who are exposed to extreme events requiring them to be emotionally detached in order to insure optimal functionality.

Michelle was brought into the center in a catatonic-dissociative condition that gradually dissipated revealing her confusion and disorientation.

Acute Stress Disorder (ASD)

Occurs 48 hours to one month post event and is the second stage of the reaction to perceived trauma. This stage is characterized by a clustering of the previous symptoms into three main clusters (DSM-V, 2013).

Intrusion. Various flashbacks from the incidents of the perceived trauma appear both as photographs and as film clips. These flashbacks, known as intrusive thoughts include other memories of the event such as noises, taste and touch, turning it into a threatening, multi-dimensional live film.

Avoidance. In an effort to depress the intrusive thought phenomena, the individual makes every possible effort to avoid any situation in which he or she might be reminded of the event.

Arousal. A reaction to the above hyper arousal symptoms that develops in response to stimuli reminiscent of the trauma (e.g., difficulty sleeping, irritability, poor concentration, hyper vigilance, an exaggerated startle response, and motor restlessness).

Acute Stress Disorder lasts in most cases for approximately one month. While it is not complicated to treat, the afflicted individual feels miserable, primarily because of the various symptoms he or she is experiencing, and the inability to control them. If the ASD has not receded after a month's time, whether spontaneously or through treatment, the individual will likely advance to the next stage of the disorder spectrum: to Posttraumatic Stress Disorder.

The immediate intervention that Michele experienced provided her with the opportunity to terminate the deterioration of the ASR she experienced into ASD and eventually prevented her from developing PTSD.

Posttraumatic Stress Disorder

Occurs from one month following the traumatic event until approximately one year or longer as in cases of prolonged and chronic PTSD (DSM-V, 2013). The event is commonly relived by the individual through intrusive, recurrent recollections, flashbacks and nightmares. There is an intense psychological distress reaction whenever the individual encounters situations reminiscent of the trauma or aspects of it (e.g., anniversaries of the trauma). In many cases there will be incidents of psychological amnesia, i.e. the repression and distortion of memories pertaining to the traumatic event.

Among trauma survivors, those suffering from PTSD, are in a state of constant agitation, restlessness, nervousness, a tendency to chain smoke and sensitivity to noise (ICD-10). Social support is an important component that influences the individual's resilience (Ellis et al., 2009). Love, support and the understanding of those individuals that are close to the survivor will enhance resilient coping patterns whereas feelings of rejection and abandonment will increase vulnerability.

Chronic Post Traumatic Stress Disorder (CPTSD*)*

Occurs from one year after initial exposure to perceived trauma and becomes a chronic condition (DSM-V, 2013). This stage is very similar to PTSD with one clear difference; the individual feels that from now on, the symptoms will be an integral part of his life and in most cases, he or she is correct. However, less than 5% of the population exposed to an event that was perceived as traumatic will in fact reach the syndrome's chronic stage. It is important to note that from the Acute Stress Disorder stage the symptoms are similar however, the prognosis worsens as the stages progress (DSM-V, 2013).

Coping and resilience. There are many ways of coping with stress. Their effectiveness depends on the type of stressor, the particular individual and the circumstances. Lazarus (1991) and Lazarus and Folkman (1984) suggested two types of coping responses, ‘emotion focused’

and ‘problem focused’: (1) *Emotion-focused coping:* involves trying to reduce the negative emotional responses associated with stress such as embarrassment, fear, anxiety, depression, excitement and frustration. This may be the only realistic option when the source of stress is outside the person’s control. Drug therapy can be seen as emotion focused coping as it focuses on the arousal caused by stress and not the problem. Emotion-focused strategies include; keeping oneself busy; letting off steam; praying; ignoring the situation in the hope that it will go away; distracting oneself and preparing to expect the worse; (2) *Problem-focused coping:* targets the causes of stress in practical ways by tackling the problem or stressful situation that is causing stress, consequently directly reducing the stress. Problem focused strategies aim to remove or reduce the cause of the stressor (McCleod, 2010). They include: *Taking Control:* by escaping from the stress or removing it; *Information Seeking:* this involves the individual trying to understand the situation; *Evaluating the pros and cons:* of different options for dealing with the stressor. Michele was using Problem Focused Coping (PFC): During the event she was focusing on activating herself and her mother, encouraging her mother to get out of the car, trying to protect her from the missile with her own body and covering her head with her hands.

The trauma does not occur solely because of the threat, but rather simultaneously, as a consequence of the perception of existence or lack of resources necessary to cope with the situation. This is the explanation for the subjectivity of the trauma: we all have various resources, adapted to our particular habits and lifestyles. However, not all these resources can be used effectively in response to the threat. During emergencies we tend to use those resources that are available and can contribute effectively to coping with the event reducing the sense of helplessness and increasing resilience. Michelle was using mostly her physical resources although generally she has a much wider pool of resources.

The term 'resilience' matured as a term during the 1970's (Garmezy, 1971) to describe an individual’s on-going efforts to cope in general with daily hardships, and

specifically with stress, while at the same time maintaining a stable balance throughout life. Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity. Implicit within this notion are two critical conditions: 1) exposure to significant threat or severe adversity and (2) the achievement of positive adaptation despite major assaults on the developmental process (Luthar et al., 2000; Masten et al.,1990; Rutter, 1990).

Most individuals do, in fact, perceive various situations as traumatic during their lives; yet continue to live and think in a positive manner, exhibiting only a slight disruption in their normal functioning during the specific period. The extent to which we can live in such a fashion, testifies to the measure of our emotional resilience. This is not to say that resilient individuals do not experience sadness following loss, but rather their general level of functionality is maintained (Mancini & Bonnano, 2006; Harvey, 2007).

One of the leading theories supporting this notion is Hobfoll's Conservation of Resources Theory (2001). It is based on the supposition that people strive to retain, protect, and build resources and that what is threatening to them is the potential or actual loss of these valued resources. These resources can come in the form of an object, state of being, personal characteristics and energies and differ from one person to the next; and are culturally diverse. Hobfoll (2001) identifies 74 specific resources classified according to four main categories: 1) material resources, e.g., home, car, etc. 2) personal resources, with an emphasis on social support. 3) resources relating to the individual's living conditions. 4) resources such as money, knowledge and credit, etc. The strength and intensity of any one resource is determined by individual, subjective interpretation. It is these resources that provide the individual with the necessary strength and resilience to cope with challenging and potentially traumatic events

This approach states that the effect of stress on an individual depends first and foremost on the perceived and/or tangible loss of one's resources. It is from this idea that the two principles of the Conservation of Resource Theory stem:

1) People who lack resources are more sensitive and vulnerable to resource loss, so that any initial loss predicts an additional future loss of resources.

2) People who conserve their resources over time tend to accumulate additional resources that can be useful in future events (Hobfoll, 2001).

This model suggests that resilience reflects man's constant and ongoing efforts to cope with adversity, hardships and crises. These efforts strengthen the individual during times of reduced organizational capacities. Therefore, during crises, the primary objective is to restore to the individual his ability to function, by identifying and developing coping skills that are situation specific (Lahad & Ben-Nesher, 2008). There is however an additional possibility that the threat itself encourages the creation of new resiliency resources. These resources are accrued to promote effective coping and resistance of the occurring threat. Forty-eight hours following the intervention at the Stress Prevention Center, Michelle was back to her normal functioning, fully independent and busy with her applications for her academic studies.

First Responders

One of the conclusions of the above discussion is the importance of immediate, professional intervention following a traumatic event. It is not surprising that the role of the 'first responder' in emergencies is intrinsic to the social work profession. "Understanding of grief counseling, crisis intervention and the trauma process represents the core professional education for social workers" (Rowland, 2013, p.131). Social work has traditionally defined one of its roles as restoring individuals to normative functioning. The holistic and strength based approaches coupled with the practice values and ethics are at the heart of the

profession (Saleeby, 2006,; Farchi, Cohen & Mosek 2013). This is why social workers can be seen at the forefront of traumatic interventions.

A Practice Protocol for Emergency and Disaster Response

Acute stress reaction (ASR). Early intervention in acute trauma situations is based on the assumption that the earlier the intervention the more likely that the victim will return to normal functioning. There is a brief window of opportunity: the first window opens during the initial 48 hours, when proper and effective intervention can very well prevent further deterioration to the ASD stage and certainly to the PTSD stage. The second window occurs during the first month of post event exposure, when focused intervention can reduce the chances of a subsequent development of PTSD (Campfield & Hills, 2001; Solomon, 1993). It is important to note that the significance of early intervention has yet to be sufficiently researched and therefore remains a matter of contention between researchers and practitioners in the field. Nevertheless, various clinical experiments do in fact report noteworthy improvement among those who received early intervention. In Israel, a concept encouraging intervention at the earliest possible stages has been formulated and adopted for use in hospitals in the military mental health unit of the Israel Defense Forces (IDF) (Farchi, 2010) and in civilian networks.

The intervention among stress victims is divided into two main stages:

1. The Immediate Stage - The ASR stage is treated on scene, in an ER or a Stress Trauma Treatment Center.

2. The Acute Stage - The ASD stage continues generally following the immediate stage for the duration of one month following the event. This stage is treated on an ambulatory basis in clinics/aid centers/mental health centers and/or welfare service departments in the community.

Intervention at the ASR stage. *Psychological*: The earliest interventions aim to reduce helplessness and increase self-efficacy. *Neurological*: Decrease dominance of the limbic lobe and increase levels of prefrontal cortex activity. The principles supporting these interventions, known as PIE, were formulated as early as World War I. (Jones, Thomas & Ironeside, 2007). *Proximity:* The intervention takes place at a location relatively close to the site of the event, by individuals from the nearest mental health services. *Immediacy:* The intervention takes place as soon as possible providing victims with fresh air, social and emotional support and initial confirmation of the event. *Expectation:* Assure the victim that his or her reactions are normal and temporary and he will soon return to his normal functioning.

This intervention was illustrated in the case described at the beginning of the chapter.

Zone 1: On scene intervention. Zone No. 1 is the scene of the traumatic event: *Michelle and her mother continue to lie on the ground long after the rocket exploded. They are picked up by the paramedics who happen to drive by.* They are at the acute stage suffering from a regressive reaction. They feel very small and insignificant in light of their inability to react effectively to the threat. Their instinctive reaction is to sever touch with reality.

The main risks at this stage include: (a) "Infecting" people close by with similar anxiety reactions, and consequently losing control of the event (especially in the case of a multiple casualty event); (b) reinforcement of helplessness, threat and fear; (c) progressive reduction in the victim's cooperation; (d) glorification of the rescuer and reduction of the victim's sense of self-efficacy and effectiveness.

Locating the ASRs in zone 1. Anxiety victims are identified by the following criteria:

1. Ineffective activity, either catatonic or agitated-hysterical
2. "Flat" (facial expression) affect

3. Inability to execute simple tasks and total dependency on responders
4. Inability to assist others
5. Acute anxiety reactions of close family and friends
6. Aggressive and/or use of verbal and physical violence towards responders

The Six-C's Model First Responders Psychological First Aid

The need for nonprofessional intervention during emergencies. Disasters have serious consequences for both mental and physical health. Norris (2005) in a review of 220 samples from natural and man-made disasters found that the overall impairment was very severe in 20.9% and severe in 38.2% of the samples, concluding that the sheer number of affected people demands a public health or collective approach. Dyregrov (2008) studied the challenges involved in early and long-term intervention to reduce distress and prevent chronic mental health problems after disasters. Their main conclusion was that there is no justification for mental health responses to be delayed for weeks after a disaster occurs. Hobfoll et al. (2007) recommended five core principles that should be used to guide intervention efforts in communities following exposure to crises and emergencies: (a) a sense of safety, (b) calming, (c) a sense of self- and community efficacy, (d) connectedness, and (e) hope. These most important recommendations underline again the need for immediate psychological interventions yet- it is aimed originally for professional teams and is focused on the *"what to do"* and not on the "*how to do it*."

Volunteers are among the most common nonprofessional group who are involved during crises and emergencies. In the absence of a formal volunteer protocol management system, individuals seek to perform services using only their own judgment which may sometimes cause more chaos than the event itself in the affected community (Fernandez, Barbera & Van Dorp, 2006). The World Health Organization (WHO) has developed a wide comprehensive manual for psychological first aid (PFA). Yet, this manual is stated to be

applicable only for low and middle income countries and is not universal (WHO, 2011). Yet other WHO manual states that the initial on scene PFA intervention can also be provided by nonprofessional helpers. Lack of standard tools for nonprofessionals can create chaos and improper interventions. Just as in primary physical first aid in which every person should know how to provide the very basic assistance in order to help physically injured people, the same need exists in the case of psychological first aid. There is a need to provide a common knowledge base for all community levels and provide large-scale but brief interventions that can reduce distress sufficiently so that survivors can benefit from whatever other supports are available in their community. This common knowledge is in the process of being assimilated into the education system in Israel, starting from primary schools. We hope that this will dramatically increase community resilience and decrease the dependency on professional mental health providers to be present in each and every disaster zone.

The SIX C'S model was created to fill this gap and to provide a simple user-friendly model based on neuropsychological and psychosocial aspects.

The SIX C's model addresses the need to standardize mental health interventions during Acute Stress Reaction (ASR) and to *shift the person from a helpless victim to a coping survivor*. It is based on 4 theoretical concepts: *Hardiness* (Kobasa, 1979; Maddi, 2006), is composed of three factors: commitment, control and challenge. They provide the needed courage and motivation to turn stressful circumstances from potential disasters into opportunities for personal growth; *Sense of Coherence* (Antonovsky, 1979), describes the psychological, social, and cultural resources that people can and do use successfully in resisting illness. It is a way of making sense of the world, and is a major factor in determining how well a person manages stress and stays healthy; *Self-Efficacy* (Bandura, 1988), is the belief in one's ability to influence events that affect their lives;

Neuropsychology reflects the relation between the limbic system and the prefrontal cortex during stressful events (Gidron, 2001). Figure 4 presents the Six C's intervention domains.

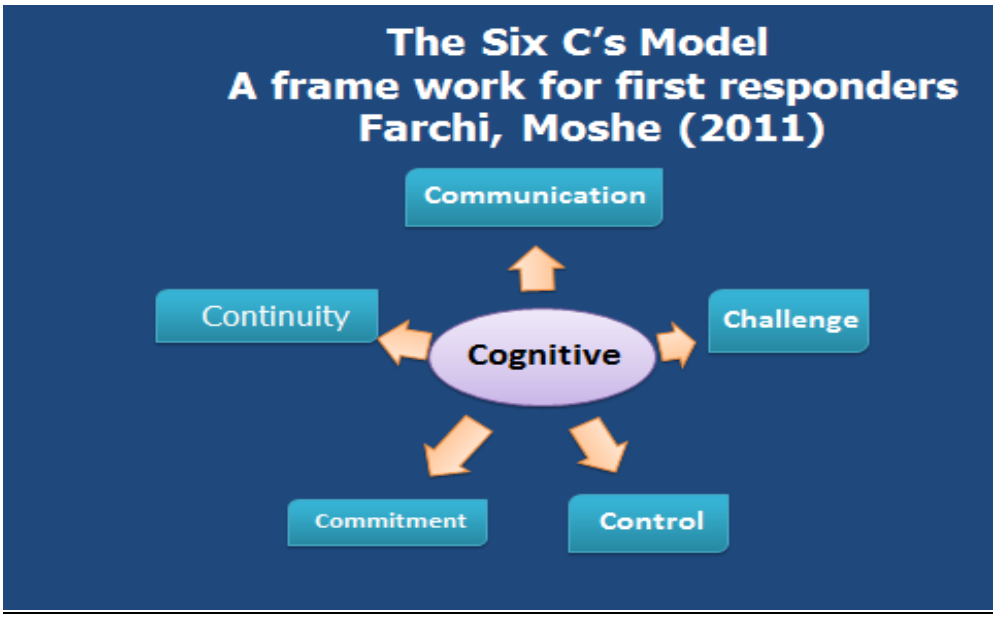


Figure 4. Six C's intervention domains.(Farchi, 2012, 2013)

Cognitive verbal communication. In extreme stress situations, functioning transfers from the frontal lobe associated with complex activity and thoughts to the limbic lobe that is associated with emotions and motivation. Cognitive communication activates the frontal lobe and weakens the limbic lobe's control in order to restore self-efficacy and perception, and enhance coping. This can be accomplished by:

1. The care provider introduces himself and describes the location.

2. Directed personal questioning, "What is your name", "Where do you live", "How old are you" and "Where do you work/study"?

3. Time based questions: "How long have you been here?" "How did you get here?"

4. Contextual questions: "What did you see?" "What did you do?" "Where did you go?"

Challenge. Activation through physical and cognitive challenges decreases the victim's regressive process and restores a sense of self-efficacy (e.g. walk person around the room and ask questions regarding past and present activities, rearrange objects in the room).

Control. Activation with encouragement to choose from different options. This provides the victim with a sense of control over his situation while empowering him. Initially, the options are simple and slowly progress to more complex choices (e.g. allow person to select between alternatives, "Do you want to call now or later?" "Do you want to wait a few minutes before going back or should we stop now?"). *Michelle is asked where she wants to sit.*

Commitment. Verbal commitment to one's safety alleviates the feeling of loneliness that is characteristic of the initial stages of ASR. Responder's commitment provides the person with a support system (e.g. responder to Michelle: "From now on I am here and not going anywhere until you feel better").

Continuity. Restructuring one's memory into a logical chronological sequence in order to prevent disorientation on both the chronological level and the perception of the event's occurrences. Reorganization of the event will alleviate anxiety and stress (e.g. responder to Michelle: "Tell me what happened…..and what happened after that").

In summary, Site No. 1 interventions must be efficient and focused and Cognitive Behavioral Therapy (CBT) based, while emphasizing activation of the victim and enhancing self-efficacy in the first few minutes after the event.

Shirr's story is now clearer: Shirr was functioning according to the *SIX C's model*: First she tried to establish verbal *Cognitive Communication* with Michelle. Not having succeeded to establish verbal communication, Shirr tried to bypass the lack of verbal communication with the hand squeezing protocol. This protocol plus continuous cognitive communication created the initial cooperation with Michelle. Shirr created the *Commitment*

by stating to Michelle that she is with her. The next step was *Challenging* Michelle to stand and start walking. In order to establish a *sense of control* Shirr encouraged her to choose between different options (where to sit, what to drink, where to go in the room). When cognitive communication was established more properly Shirr encouraged Michelle to talk about the event and helped her to put the events into the right chronological order. That was done to establish the sense of *Continuity* and to underline that the threatening event was already over.

Mezzo Level Practice: Group Interventions

Group intervention principles are fairly similar to individual interventions. However, group intervention has both organizational and therapeutic advantages. It saves professional manpower. This is particularly important in case of mass-casualty events in which there generally is a shortage of professional first responders. While individual intervention requires one care provider per casualty, group interventions can be implemented with two care providers for up to 12 participants per hour (Somer & Bleich, 2005). The therapeutic advantage is that the group enables participants to conduct a more detailed examination of the event as each one adds missing details.

The objective of group intervention is to restore the victims' sense of familiarity and control and reduce disorientation through group dynamics (Somer & Bleich, 2005). The group is comprised of individuals who have recently undergone a similar experience. This shared environment reduces loneliness and provides mutual support. The ability of each member to give or receive support contributes to creating a safe environment and facilitating a feeling of control and autonomy. The group members assist each other in reconstructing their narrative of the event's occurrences while filling in missing details. Reconstruction improves understanding of the difficult event being in the past and not in the present. Survivors, who often express negative interpretations related to their functioning during the

event, receive an opportunity to reframe their narrative, thereby presenting their actions in a more positive light. Initiated and controlled repetition of the event's details serve to reduce disorderly and overpowering intrusive thoughts. It also facilitates desensitization - a central objective in any Cognitive Behavioral Treatment.

A Recommended Protocol for Immediate Group Interventions Following Exposure to an Emergency or Disaster

Previous attempts at treating the ASR and in prevention of PTSD have often included various types of debriefing which mostly have failed to prevent the ASD and PTSD (Arendt & Elklit, 2001; Mansdorf, 2008; Rose et al., 2002). Furthermore, reviews of the effectiveness of early interventions in preventing PTSD have concluded either that there is no evidence for their effectiveness (Roberts et al., 2009) or that only cognitive-behavioral therapy may prevent PTSD (Roberts et al., 2010). Similarly, a recent review of 19 intervention trials found no evidence for debriefing and some evidence for the effectiveness of early trauma-focused cognitive behavioral treatment (Gartlehner et al., 2013). Neuro-scientific studies have revealed that perceived trauma is processed in fragmented and implicit memory processes(Van der Kolk & Fisler, 1995; Foa et al., 1991, Hendler et al., 2003) and pathological conditions are associated with trauma processing in brain regions reflecting little prefrontal and enhanced limbic activation (Shin et al., 2004). Such findings call for an attempt to shift the processing of traumatic memories from fragmented and limbic manners to more organized and prefrontal manners. It is possible that our focus may need to shift from relatively simplistic trauma narrative-based and emotional ventilation based interventions to interventions based on a neuro-scientific rationale and/or on intervention strategies from stress models, to reduce the ASR and ultimately, to prevent PTSD, and enhance recovery. Neuro-scientific studies have revealed that perceived trauma is processed in fragmented and implicit memory processes

(Van der Kolk & Fisler, 1995; Foa et al., 1991; Hendler et al., 2003) and pathological conditions are associated with trauma processing in brain regions reflecting little prefrontal and enhanced limbic activation (Shin et al 2004). Such findings call for an attempt to shift the processing of traumatic memories from fragmented and limbic manners to more organized and prefrontal manners. It is possible that our focus may need to shift from relatively simplistic trauma narrative-based and emotional ventilation based interventions to interventions based on a neuro-scientific rationale and/or on intervention strategies based on stress models, to reduce the ASR and ultimately, to prevent PTSD, and enhance recovery.

Based on the Six C's Activation Model the objective is to return participants to routine functioning by taking the following steps:

1. Explain the session's objective;

2. Summarize the event from the moderator's point of view;

3. Emphasize the challenges, both individual and collective;

4. Ask group members to add information/facts;

5. Have participants share their coping strategies in each stage of the event;

6. Have group members suggest points for improvement;

7. Have a moderator to improvement strategies what should conserve and what should be improved;

8. Define a detailed and concrete timetable beginning with the session and conclude with a return to normal routine;

9. Group members summarize the session;

10. Moderator summarizes the session.

Helping the Helpers

Working with traumatized clients can have profound, long-lasting and harmful effects on the helpers. Various terms to describe the phenomenon have been suggested. Herman (1992) used the term traumatic countertransference to describe the reactions that are experienced when the therapist's traumatic past experiences are triggered during therapeutic intervention with traumatized clients. Figley (1995) offered the term compassion fatigue to describe the stress resulting from helping or wanting to help traumatized or suffering clients. Eth and Pynoos (1985), and Mollica (1988) suggested that therapists become "infected" by contagious PTSD symptoms. Likewise, McCann and Pearlman (1995) proposed the concept of vicarious traumatization (VT) to portray the cumulative negative effects of engaging in a therapeutic relationship with trauma victims. This concept is based on a constructivist self-development theory (McCann &Pearlman, 1990; Pearlman & Saakvitne, 1995) and is assumed to affect the same general aspects of self as those affected by traumatic life events: self-capacities (e.g., management of affect, sense of self-worth), frames of reference (e.g., identity, worldview, basic beliefs and psychological needs; (e.g., safety, esteem, control), and realms of perception and memory (e.g., verbal, somatic, visual imagery).

Stressors Associated with First Responder Work

- Exposure to unpredictable physical danger;
- Encounter with violent death and human remains;
- Encounter with suffering of others;
- Negative perceptions of disaster and assistance being offered;
- Long hours, erratic work schedules, extreme fatigue;
- Cross cultural differences between workers and community;
- Lack of adequate housing;
- Communication breakdowns;

- Low funding/allocation of resources;
- Over-identification with victims;
- Injury of self or close associate;
- Pre-existing stress or traumatization;
- Low level of training or preparedness;
- Self-expectations;
- Low level of social support.

Helping the Helper Protocol

- Self-preparation before the event;
- Before arriving to the disaster zone:
    - *Cognitive*: Go over all the main protocols that are the most common and most expected;
    - *Communication*: Consult with colleagues;
    - *Challenge*: yourself with more unexpected scenarios;
    - *Control*: try to choose between different interventions options for the expected scenario;
    - *Continuity:* go over (imaginary) different stages of the most expected protocol from beginning to end.

Macro Level Social Work Interventions in Trauma and Emergencies: The Israeli Experience

The Israeli reality requires social workers in general and particularly those employed in Social Service agencies and hospitals to have emergency response skills. Unfortunately, Israeli social workers have had too much hands-on experience. The ongoing terror attacks, suicide bombers, Scud missiles and sniper killings on the borders in addition to natural disasters, have demanded immediate and efficient professional response on the part of our

practitioners. The common denominator of all these interventions is the need for immediate and first-hand response addressing multiple needs.

Until 2006, each organization and agency implemented its own protocol. In 2006, with the outbreak of the Second Lebanon War, and following a growing understanding of the importance of developing a standardized policy for first response intervention, a number of Stress & Trauma Treatment Centers were opened. The rationale of these centers was the understanding that the best location for these centers was not within the confines of the ER or local hospitals, but rather in specially designated areas, unrelated to any specific "illness".

The Center's Objectives are to 1) provide initial care to anxiety and trauma casualties in the acute stage that occur from the moment of injury +2 days following (Acute Stress Reaction). 2) Create a neutral setting in the community in conjunction with local social services that would not have the stigma of physical or mental illness. 3) Create a location to which stress casualties can be quickly evacuated.

The number of identified anxiety casualties during the Second Lebanon War was nearly 2,700 individuals. Only 500 of those injured were treated at seven Stress & Trauma Treatment Centers set up in Northern Israel (from Tiberius to Nahariya). A number of years later, in 2008, during Operation Cast Lead, of the approximately 1,800 individuals who were identified as suffering from anxiety symptoms, 1,300 were treated in the various Stress & Trauma Treatment Centers. By the time Operation "Pillar of Defense" took place in 2012, the overwhelming majority of anxiety casualties received treatment in Stress & Trauma Treatment Centers and not in hospital emergency rooms. This, obviously, has an important effect on the quality of treatment that is provided by both hospitals, who can offer better care for the physically injured and the Centers who can provide better care for those in need of psychological first aid. Furthermore, Israel's National Insurance Institute, responsible for compensation related to civilian war injuries, has recognized for the very first time, the forms

issued by the Stress & Trauma Treatment Centers as an official medical document for all stress related compensation claims.

A Community Intervention Case Study: The Town of Ofakim

The vignette described at the opening of the chapter depicts one story of one person out of many residents in the Ofakim community.

Ofakim is a small town in the south of Israel recently targeted by the Hammas rockets. Our interventions were based on the Six C's protocol as an "umbrella" model. In addition, a more focused intervention covered three areas:

1. 24/7 manned hotline available to those individuals who were too frightened to leave their home bomb shelters and reach the PFA center. Most calls were from parents asking for advice regarding their children's anxieties and stress caused by the massive rocket and missile attacks.
2. Face to face individual or small group treatment: for those who came to the centers.
3. Community outreach: Initiated day and night patrols throughout the various neighborhoods and shelters were conducted by students wearing orange glowing vests so that they could be identified by the residents. People identified as suffering from ASR were treated in place.

Figure 5
(Farchi, 2013)

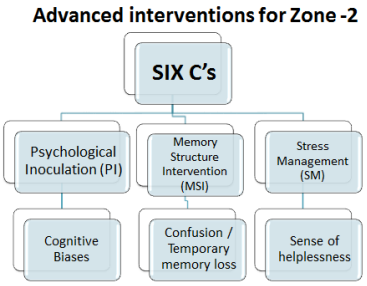


Figure 5. Advanced Interventions for Zone 2 (a safe area that is not on scene of the event in which advanced intervention protocols can be applied by professionals).

Results of the Interventions

Figure 6 Results of the interventions.
(Farchi, 2014)

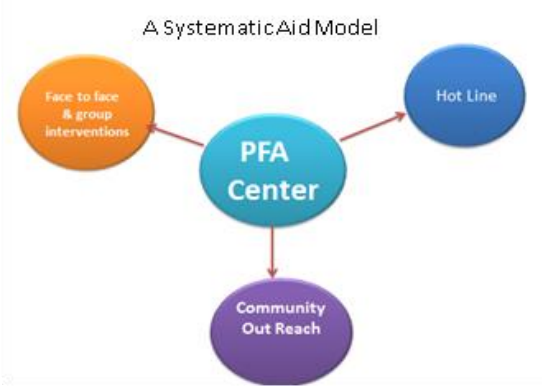
Changes in anxiety level before and after Six C's orientation (using MSI + VB, PI, SM)

Anxiety symptoms	Mean before	Mean after	t-test	Significance
Anxiety level (Autonomic reactions, emotional balance)	4.9	2.12	6.90	P<.000
Anxiety level – patient report	8.54	4.23	10.03	P<.000
Anxiety level- therapist estimation	4.00	2.32	3.3	P<.001

Over a period of eight days, 250 individuals were treated for various stress reactions in the towns of Ofakim and Kiryat Malachi. None of the patients required hospitalization or even referral to a hospital. Even the most acute cases of stress showed significant recovery after no more than 45 minutes of treatment. The use of the Six C's model proved its effectiveness as a basic model for stress interventions.

The combined working model of treatment at the Center, telephone hot line and initiated patrols in the community proved most effective in providing the local residents with a sense of safety and increased community resilience.

Figure 7. A systemic aid model
(Farchi, 2014)



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Conclusions

The aim of this chapter was to identify the mental health needs of civilians exposed to emergency and disaster events and delineate the role of the social worker as a first responder. Traditionally seen as an agent of social change, social workers are expected to provide immediate, precise and effective interventions, aimed at restoring normative functioning to the community, the group and the individual. They work as part of a team of emergency workers, e.g. medical, EMT, firefighters, Search and Rescue (SR) units, forensic teams, K-9 search units and other forces,

Specifically, in the event of an emergency situation this means alleviating stress symptoms and enhancing self-efficacy and resilience in those individuals impacted by potentially traumatic events. This is implemented by: 1) opening and managing information centers; 2) transmitting relevant information to those calling in for assistance; 3) providing assistance and emotional support to individuals suffering from ASR and their families; and 4) accompanying family members to the morgue/forensic center in the event of a death.

While this concept focuses on the many needs that arise during emergencies, and the relevant effective interventions, it also emphasizes the need to provide appropriate training to enable these functions. This type of training is rarely offered in the basic Bachelor of Social Work (BSW) curriculum and only partially implemented in a number of graduate programs. This is what makes the Tel Hai College study track of Stress and Trauma Studies an important program. The current overview has provided a theoretical knowledge base for social work interventions in emergencies and disasters. It also provides a hands-on manual for mental health first aid interventions on the individual, group and community level. Being able to provide professional assistance immediately following an emergency situation thus reducing the chance of PTSD onset has long range psycho-social and economic effects. The

combination of professional PFA training models on the one hand and the Six C's model to be used by non-professionals on the other, dramatically increases community ability to provide PFA during any kind of emergencies, thus enhancing community resilience.

Internet Resources

- *IDF Homefront command* – www.oref.org.il
- Eran telephone mental health first aid – www.eran.org.il
- Magen david Adom – www.mdais.org.il
- Stress, Trauma & Resilience Studies program – Tel-Hai College http://english.telhai.ac.il/content/stress-trauma-and-resilience-studies-program
- The times of Israel IDF treats hundreds of soldiers for PTSD-like symptoms post-Gaza Nov, 29th 2014 http://www.timesofisrael.com/idf-treats-hundreds-of-soldiers-for-ptsd-like-symptoms-post-gaza/
- Special Israeli ambulance treats shock victims HAAretz, nov, 20, 2012 http://www.haaretz.com/news/diplomacy-defense/special-israeli-ambulance-treats-shock-victims.premium-1.479115
- Haiti's earthquake: CNN Student News Transcript: February 5, 2010 http://edition.cnn.com/2010/US/studentnews/02/04/transcript.fri/

Discussion Questions

1. What are the advantages of immediate intervention at times of disaster?
2. What is the rational of the six elements of basic interventions during emergencies? Explain.
3. How can we identify a traumatized person? What are their basic needs?
4. What is the difference between "perceived trauma" and what is "traumatic event"?

5. In the macro perspective – How can we apply the SIX C's model to encourage community resiliency?

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To cite this article:

Hantman, S; Frachi, M. (2016). From Helplessness to Active Coping in Israel: Psychological First Aid. In: Transformative Social Work Practice, Chapter 32. Schott, E. Weiss. E.L. Sage publication