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The good Voice -Terror Witnessing: From Time of War to Time of Healing

Dr. Yaelle Chouraqui-Elfassi

Center for International Relations and International Security
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Introduction

The land of Israel is currently navigating challenging and distressing times. The abrupt shift from the celebratory high holidays to the disturbing terror acts of Hamas has deeply affected a new, contemporary generation. This generation, accustomed to a strong sense of security and the comfort of life in the Jewish homeland, had hoped that any future conflict would involve a 'clean' cyber war fought from the safety of their own living rooms.

The national memory, intertwined with the Yom Kippur War and the captives, revives a national trauma. The belief in our strength and the feeling that we would never again witness horrendous scenes shatters and reveals wounds that have yet to heal. Revisiting a time of warfare with Iron Swords and tanks, images of Jews suffering in inhumane conditions, not tolerated for their Judaism, even within their own land, is unsettling. The intensity of cruelty, the loss of basic moral principles, the slaughter of women, children, and infants, and scenes of horror—these transcend beyond the terrifying wounds inflicted upon us, causing severe disruptions in our perceptions and affects.

In these days, we are all witnesses to terror and affected by it in one way or another. Within the framework of this article, I aim to depict the concept of ‘terror witnessing,’ outline this experience in general terms, and propose appropriate intervention principles. In doing so, I will address the unique highlights of our current situation due to terror witnessing as an entire nation. This is to contribute, to the rapidly accumulating body of knowledge for the intervention and treatment of the numerous victims of the attack and war drawing from my research and therapeutic experiences.

Terror witnessing

One of the concepts I addressed previously in my research 'The Invisible Victims' Experience of Terrorism – Miracle or Disaster' (Chouraqui-Elfassi, 2006) is the witnessing to acts of terrorism. Under this general heading, I included people who were witnesses to severe acts of terrorism but were not directly affected, or those who witnessed the difficult events or heard of it through the media. Naturally, it is essential to refer to witnesses who were present at harsh incidents as they were exposed and affected in one way or another. However, in my approach, I aimed to emphasize the importance of addressing the broader audience who, in the modern age, observes horrific scenes from the comfort of their living room, such as during the terrorist acts on the Twin Towers when millions of people watched live as people jumping out from the building windows to their death and other horrifying scenes. Thus, the public becomes a witness to terror (Nader, 2001). Despite the fact that we live in an era where there are terrorist attacks worldwide, and many people are exposed to this, it is interesting to note that when I began my research, there was almost no available literature about terror witnessing.

According to my perception, there are unique signs and characteristics to terror witnessing (Chouraqui-Elfassi, 2006). One of them arises from the fact that a central feature of terror is the potential for random harm to any person and any place (Tal & Pearl, 2001). The very existence of this potential penetrates the core of the initial psychological devastation that corrodes within. The chilling knowledge is that no one is truly protected. This intensifies even more for those who may have been in places where acts of terror occurred or are frequently found there, experiencing difficult and complex feelings in this regard. This population is referred to as 'near-miss survivors' (Kalish, 1994).

In my research, it was found that all terror witnesses exhibit, at least one or more symptoms of post-traumatic stress disorder. Among the symptoms they endured were persistent anxiety states and panic attacks.

Consequently, it can be inferred that extensive exposure to horrors turns us into witnesses of real trauma, which can significantly impact the core-self over the long term. These findings encourage further research on the effects of exposure through media to terrorism and traumatic events in general on the development of post-traumatic disorders. Presently, there is still no professional consensus that those exposed to traumatic events through the media constitute a population at risk for developing post-traumatic stress disorder, as indicated, for example, by the criteria of diagnosis and statistics outlined in the DSM (Diagnostic and Statistical Manual of Mental Disorders).

One more unexpected discovery uncovered in my research is that unlike non-terror traumatic events, participants lack the marker of memory erasure (even though there was a sense of memory impairment). In other words, when it comes to terror witnessing, the memories of exposed witnesses are vivid and precise (the terrifying moments before the event, the event itself, and thereafter).

Furthermore, according to research, in the case of terror against a nation, such as in the current situation in Israel, there is a unique state: on one hand, everyone is gripped by fear to varying degrees, as every place poses a potential threat. On the other hand, there is a strong sense of resilience and continuance of life, despite the unbearable situation, which empowers others—which is addressed further in the article.

Terror Witness Impact

The impact of terror witnessing and the responses it encompasses vary significantly from person to person and depend on various factors (the type of terror event, level of exposure, individual personality, self-perceptions, past experiences, support systems, and more). However, despite individual differences, several types of reactions and key challenges emerge from research. Some are unique to terror witnessing, while others are characteristic of experiences from different types of traumatic events:

De-legitimization: One of the unique features that emerged from my research is the fact that witnesses felt de-legitimized as victims. They were not physically injured or killed, therefore they believed they had no right to complain or feel victimized. This is despite the fact that many of them actually suffered from post-traumatic representation. Due to this feeling, witnesses might feel that they have no place to tell their story and might refrain from doing so.

Guilt: Feeling guilt in traumatic situations. For example: "I'm not well," "I'm not contributing enough," "everyone is contributing," "I have forbidden or embarrassing thoughts (to desert/to escape/to leave)," "I'm not caring enough for others in times of hardship," and thought of this nature. In trauma witnessing situations, there's an additional guilt, survivor's guilt, which raises the question among the witnesses: "Why were they 'chosen to be saved' and not others?" (Vergolias, G. L. 1997). In this context, one of the findings in my research was that most witnesses made a dramatic professional change post witnessing, moving to professions that provide nourishment, usually therapeutic professions. The reason was that by doing so, they felt a justification for their existence.

Isolation: Occasionally, isolation is one of the anxiety features accompanying trauma. This applies even to individuals engaged in vital professions such as doctors, therapists, teachers, and more. Although occupation is positive and useful, and there is often a push to encourage witnesses to act, it must be understood that not everyone can cope with employment.

Anger: Feelings of anger also appear: anger towards politicians, the state, army personnel, and anger towards God, towards oneself, towards family members. For example: "How do they think such thoughts at such a time?" "Why aren't they considerate towards me when I need peace from all this tension?" "How do they not help at such a time?" "Why are they arguing in such a difficult time?"

Feelings of Failure: Feelings that can manifest in various ways in these situations. For example: "I failed as a parent," "I broke down and frightened my children," "I failed to protect them," "I didn't draft to the army," "I drafted to the army and left my family alone to cope," "I can't console my wife," and more.

Non-visual becomes Visual: Coping with visual images seen on-site or in the media is indeed difficult. Additionally, as revealed by my research, there are images that were not seen. In situations where witnesses are heard and there's exposure to alerts or difficult stories, the non-visual becomes visual, and the images that arise in the imagination take on real visual vitality that needs to be coped with. These images can surface uncontrollably in consciousness and must be coped with.

Speech/Silence: Some people have a desire to talk about what they have experienced or seen and what they are going through now, while others have a desire to be silent, self-contain, focus on self-listening.

Loss of Humor: In many conflict situations, there is an attempt in thought or speech to see things from a different perspective and use humor for healing. In severe crisis situations like the ongoing war in Israel, this perspective was taken from us. Only the reality on the ground and the mental reality remained. This significantly intensifies the difficulty and complicates coping, preventing any dimension of escapism.

Good Mingled with Bad: Scenes perceived as positive, soothing, or joyful in everyday routine situations can mix and generate opposite feelings of pain, fear, and anxiety after terror witnessing. For example, children's drawings, children are asleep, an empty stroller. That once seems ordinary now perceived as dark and traumatic given terrorism impact context.

Disruption of Routine: Reactions to terror witnessing can also manifest in disrupting habits and daily routines. For instance, changes in sleep patterns and erratic eating, people waking up in panic, feeling chest pains, anxiety, difficulty eating and other change in what is known as ordinary behavior.

Intervention Principals

It becomes evident from my research findings as well as my personal experience in therapeutic sessions with patients the distinct stages in the psychological processing of witnessing terror. This trend is much like the processes observed in loss and mourning. Furthermore, advocating for conversation or treatment might not always be the most fitting response, particularly in the initial phases. It is more beneficial to support individuals exposed to trauma with a 'step-by-step' approach rather than trying to guide them towards a specific theoretical treatment direction.

The patient’s adjustment of treatment depends is individual and depends on many factors such as person’s personality, childhood experiences, previous trauma, resilience etc. Generally, in the initial stages, witnesses aren't ready for treatment but are more focused on organizing the ‘core-self’ (reorganizing their thoughts and life, finding both physical and mental stability to hold on etc.). Furthermore, in situations of indirect exposure to traumatic events and proximity to the event, it's recommended that the individual undergo tailored initial intervention before seeking treatment. The preparation for this treatment is a time-consuming process. The reason is that disassembly (treatment and touching upon trauma) cannot be allowed before creating a renewed stable structure. For example, a patient came to me four years after being in a car in which part of her family was murdered, and she was also attempted to be murdered. She came for treatment four years after the incident, from the day of her witnessing to the attack. Only then was she able to speak and 'touch' the trauma.

Throughout my years of providing treatment to victims and holding a management position at AVNET, the first Israeli association for terror victims in Israel, we discovered that individuals often required a period of 'organization' and structure for months, or sometimes even years, before they could engage in conversation. At the beginning of my journey, even before I was a professional, I initiated meetings with terror victims across the country, and crowds arrived. Due to the high response, I invited clinical psychologists to guide the next meeting. Surprisingly, no one showed up. In another subsequent meeting without therapeutic guidance, the entire audience returned. The difficulty in talking and the time required before treatment meetings to face the trauma 'face to face' has been expressed in various ways over the years.

When a person is ready and seeks treatment, it's important to tailor the therapeutic response and treatment specifically to their needs, while identifying the person's triggers, fractures, injuries, and identifying their resilience and strengths:

Identifying the Fractures:

In a state of trauma, one's stable ground trembles, and the person's core –self and foundation are shaken. This state often has an impact on our deepest ideological perceptions and beliefs, those that served as internal protective resources for us in normal situations. Confidence in the country, in the military, in one's family, in the belief that the world is good, that the self is strong, that the future is bright, the belief in God—all of these can cause instabilities (ground trembles) and leave one's core-self feeling exposed and unprotected. These deep internal trembles and therefore fractures require reconstruction. Therefore, it's important to invest in an internal restorative process after identifying and diagnosing each person to locate the existence of these fractures.

Identification of Life Cycles and Coping Methods:

Professor Edna Foa, an Israeli researcher and a global expert in the field of trauma, describes three fundamental life cycles of an individual: the perception of oneself, the perception of the world, and the perception of the future, which are affected and vulnerable to upheaval due to exposure to a traumatic situation (Foa, 2011). Based on this understanding, therapists need to ask meaningful questions, such as: Do the positive and stable resilience factors before exposure to the traumatic situation strengthen or weaken these three cycles in the exposed individual? That is, whether the collapse of a sense of previously unshakable security before exposure leads to a

breakdown, or conversely, the individual's natural resilience factors and positive perceptions continue to support them during trauma exposure. Before providing therapeutic responses to trauma victims, it's crucial to investigate and understand these cycles and their influence on the exposed individual to provide appropriate responses. Generally, and although needs to be personalized tailored, there are several principles and emphases for treating terror victims that are important for us as therapists to keep in mind:

Encouraging Coping Mechanisms: It's important to remember that there isn't one appropriate way to act or cope in dire situations, and it's essential to help patients see the internal logic and strengths in their coping mechanisms. It's also important to help them release their guilt about anything they didn't do or weren't able to protect (themselves or others).

Not Everyone Has the Same Strengths: It's important to remember that each person is constructed differently, and their needs vary. Not everyone was born the same, and not everyone has absorbed the same baggage throughout their lives. Everyone has different strengths—some are stronger, others are weaker. Therefore, we should not demand a specific goal from our patients. In light of this, the patients' recognition of their own needs and strengths is important; it can assist in self-acceptance and alleviate feelings of guilt or failure.

Reducing Exposure to Media: The desire to know and be in control is a basic need that cannot be ignored. Sometimes, it is expressed by the wish to be constantly connected to the media. It's essential to explain to patients the dangers associated with this and provide recommendations or guidelines to reduce exposure.

Treatment for Anxiety: In treating anxiety, it's important to understand that it doesn't come from a decision or control. Also, eradicating the anxiety does not treat it. Avoid reactions

that aim to help but in fact harmful, like saying "You must understand that you're scaring the kids with your behavior," or "By not eating, you're just harming yourself." On the contrary, listening to the anxiety, embracing and supporting surrounding, and statements that point out secure foundations in reality are stabilizing and healing, allowing the individual to stabilize during the process.

In addition, people suffering from panic attacks or ongoing anxiety with physical symptoms develop anxiety about the anxiety itself over time. It's important to allow them to voice these feelings out loud, which can be intimidating. Voicing these feelings to anyone, even a non-professional, who can hear the anxieties, might help significantly.

Positive Passive Viewing of Life Continuity: One of the things that help in coping with stressful situations is to see the world continuity in its natural course. For instance, there are people outside, the grocery store is open, and babies are playing. It's important for us, as therapists, to understand that an individual's exposure to life is significant, even without forcing them to be present and without requiring them to act in order for it to benefit their feelings. Understanding the importance of this can help guide the individual to places where they can be exposed to life's continuities, even if they are not active participants and are merely observing.

The Need to Hear a 'Good Voice': In the midst of chaos and horror, individuals experience trauma need to hear 'that everything is going to be OK!'. In the field of developmental psychology usually this phenomenon of inner voice ability is mentioned when parents transcend it to their children. They voice to their children and the hope is that the latter be able to voice it to themselves in difficult times. During trauma moments, we find it difficult to access these voices and revert to an early regressive state where we seek to hear these voices from outside.

The ‘good voice’ always raises a very difficult dilemma around many theoretical treatment perceptions. We often leave the voice aside, many of us therapists don't want to give hope where there might not be any, believing that in treatment it's important to keep the black as black without making it easier because it's hard for us, and for many other deep reasons. But when dealing with survivors, it's very important to listen to this voice. This voice can definitely be heard within the framework of treatment, but also beyond it. The positive and influential voice ought to resonate from various sources: from individuals to their peers, from parents to their children, from influential figures and politicians, from military commanders to their soldiers, and from societal leaders to the community at large. Each of these voices has the potential to substantially contribute through fostering 'the good voice,' reinforcing and empowering both individuals and the community as a whole.

What methods can be employed to enlist this 'good voice' during challenging times? A powerful approach to summoning 'the good voice' involves drawing strength and hope from the prospects of the future. For example, to the current situation in Israel: thinking about the achievements of the war that will bring broad peace and stability for many long years to the residents of the southern region and the for the whole country.

Shared trauma witnessing:

During periods of conflict such as war, there is a collective experience of witnessing terrifying events. In professional literature within this context, a frequently referenced concept is "undoing aloneness." (Fosha, 2021). This concept describes the significant importance of solidarity in a situation of shared trauma. However, in the relationship between a therapist and a

survivor, dilemmas and complexities arise regarding this partnership, which requires careful consideration.

Therapists find themselves in a position where, on the one hand, they want and need to listen to the survivors. On the other hand, they attempt to avoid potential fears that may threaten them as well. The overwhelming anxiety in such situations may be so severe that it doesn't allow the therapist to confront their own emotions. This might negatively impact the treatment, preventing the survivor from encountering the darkest rooms they need to face to heal (Herman, J. L. 1992). Besides the difficulty of encountering this fear, therapists are also concerned about potential damages such as experiencing breakdowns, which could be expressed by the patient or by themselves through the mere act of touching the fear (Cohen et al., 2014). Due to these concerns, therapists may exhibit empathic failures, like incomplete or inattentive presence or a conscious or unconscious effort to divert attention away from topics that raise fear and anxiety among the people involved in the therapy, which can hinder the treatment and often result in a decline in the therapist's self-worth (Somer et al., 2004; Tosone et al., 2012).

Boulanger (Boulanger, 2013) describes how symbolic it was when, after Hurricane Katrina in New Orleans, the therapist and the patients were forced to climb over the ruins of buildings in order to reach the clinic. This situation symbolized and highlighted the fact that the patient and therapist were dealing with the same 'problem' directly. Boulanger raises the difficulty for therapists in providing a secure space to process difficult experiences when they themselves are exposed to the same terror. Additionally, he describes the public's expectation for therapists to excel at taking care of others due to their occupation. As a result, he argues, an extreme sense of isolation is created among the therapists.

Another challenge that arises in situations of collective trauma witnessing is blurring the boundaries between the therapist and the patient. In cases of collective trauma, both sides face difficulties and are exposed to terror. This, which is evident to the patient, doesn't often happen during normal times when the therapist can hide personal stressors they're exposed to. Consequently, the patient may be more interested in the therapist's well-being. The therapist, in turn, might share thoughts or feelings that they typically wouldn't express in order to maintain the patient's central role and prevent external influences on the treatment. Sometimes, this leads to a negative diffusion of personal and professional lives (e.g., "I was also very scared yesterday when there was an alarm"). On the other hand, such sharing of emotions by the therapist may significantly strengthen the patient and dispel their sense of loneliness, as argued by certain critical and feminist approaches to therapy today (Weiss, 2003). Therefore, it's crucial to reassess the specific fit of each shared moment for the particular patient.

Another challenge faced by therapists in such situations is the need to balance their professional lives with their personal lives and care for their own families in times of need. This dilemma, the conflict between patients in need of assistance and the therapist own family support needs, might create a crisis in the therapist live and complicates the regular dedication that many therapists have towards their patients (Baum, 2012).

In Conclusion

The concept of terror witnessing, as described in this article, urges an expanded perspective on the trauma's ripple effects beyond direct witnesses, extending to indirect witnesses through media, amidst the difficult and painful days we are experiencing in Israel. It

may allow for a more precise therapeutic response to numerous affected individuals in a country facing narrower definitions of exposure to trauma, many of whom might feel neglected. Addressing terror witnessing and the potential traumatic effects demands an understanding of the unique components of the witnesses' experience, a proper assessment of their trauma, and delivering a tailored response and treatment to each person facing their own weaknesses, their strengths, and capabilities. This should primarily focus on contemplating potential positive outcomes of the struggle while searching for the "good voice" – to listen and express it – in order to navigate through these challenging times.

Alongside the intimate personal approach, I believe there is a parallel need for national therapy, which functions as a comprehensive treatment aimed at the recovery of an entire nation which is exposed to severe and distressing events, serving as witnesses to these experiences. National therapy can be executed by individuals of compassionate influencers, offering them a significant and vital role derived from their experience within the realm of handling crisis situations. This role could be established through encouraging speeches to the community and via educational programs addressing and facing the deep disappointments by creating a profound and rooted connection to the nation's history, its significance, and the hope that arises from an understanding that we are in a process – a long path that has goals and progression. Even within psychological treatment, it's valuable to integrate processes that address disappointment while also providing strength, purpose, and genuine national hope to the whole.

I conclude by calling the known Hebrew saying “Hezak V’ematz” ("Strengthen and Embrace") for the residents of the South of Israel who have endured heavy suffering for years, especially to their families, the heroic soldiers and their families, and to all the people of Israel. I cite the words of October 7th catastrophe hero from Kibbutz Be'eri, Haim Yalin, who said: "We

shell once get back here to this land!". The war began, causing tremendous pain and turmoil, and following it, many touching expressions of compassion emerged from all sides of the nation. Eventually, there will be recovery, healing and reconstructing.

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