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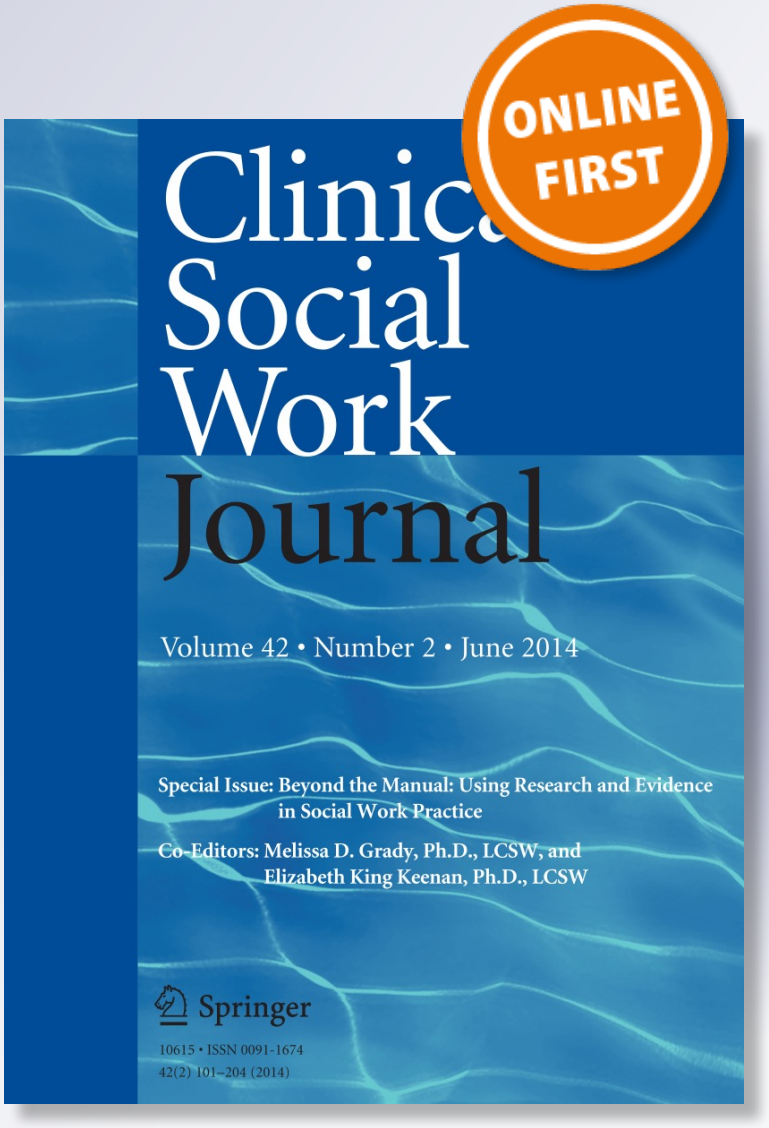

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ORIGINAL PAPER

"Common-Fate": Therapists' Benefits and Perils in Conducting Child Therapy Following the Shared Traumatic Reality of War

Esther Cohen · Dorit Roer-Strier · Mazal Menachem · Shira Fingher-Amitai · Nitzan Israeli

Abstract In this study we examine the experiences of 70 therapists who treated children identified as suffering from posttraumatic distress following the shared traumatic reality of war (the Second Lebanon War between Israel and Hezbollah). The data are based mainly on qualitative research methods: focus groups, therapy narratives, and "member-checking" interviews, supplemented by quantitative data from questionnaires. Nearly all the therapists reported being affected by the war and half of them reported additional vicarious traumatization resulting from exposure to the children's experiences. Therapy work with children was experienced as particularly challenging, yet involving high levels of work satisfaction. The perception of an intergenerational and concurrent "common-fate" between the therapists and the children contributed to increased empathy and the forming of an emotionally intense and care-giving relationship with the children. The therapy focused mostly on emphasizing the children's strengths and building strategies for coping, and provided the therapists with a sense of agency and helpfulness. It also allowed the therapists an opportunity to rework their own traumatic childhood memories that tended to emerge unexpectedly during the sessions. Concurrently, posttraumatic distress experienced by the therapists seemed to present a potential barrier for their therapeutic availability and to lead to a defensive avoidance of the children's painful memories. Therapists found the work itself, in addition to the use of individual psychotherapy, supervision, and peer-support to be helpful in coping with their primary and secondary traumatic reactions.

Keywords Shared traumatic reality · Child therapists · Common fate · Child therapy · Post-traumatic distress · War · Avoidance

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Introduction

This paper attempts to highlight the special dynamics involved in therapeutic work with children in situations in which both therapists and their child-clients are affected by the same collective traumatic events. Conducting psychotherapy with survivors of traumatic events is being increasingly recognized as a complex clinical endeavor involving unique personal experiences and professional challenges for therapists (Craig and Sprang 2010). Pearlman and Saakvitne (1995) use the concept "vicarious traumatization" (VT) to describe the transformation in therapists' cognitive schemas and belief systems resulting from their empathic engagement with survivors of traumatic

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experiences. The "contagious" aspects of the patient's symptoms affecting the therapist are further highlighted by Figley (1995), who uses the term "secondary traumatic stress", and by others using similar concepts, such as "secondary traumatization" (Stamm 1995). Figley (1995) additionally refers to "compassion fatigue" to describe the state of exhaustion and dysfunction resulting from prolonged exposure to emotionally needy and suffering clients and the cumulative pressure of attempts to help them.

In a move away from deficit models, the concepts "compassion satisfaction" (Figley and Stamm 1996) and "posttraumatic-growth" (Tedeschi et al. 1998) have been introduced to point out that therapists can also be influenced by their traumatized clients in positive ways. Compassion satisfaction is found to be quite prevalent and may serve as protection against the negative effects of treating traumatized clients (Craig and Sprang 2010).

A relatively recent focus in the field of trauma therapy involves delineating the special challenges facing therapists affected by the same community traumatic events as their clients, such as political violence, wars, and natural disasters. Scholars use such terms as "shared trauma" (Saakvitne 2002), "shared traumatic reality" (Nuttman-Shwartz and Dekel 2009), or "shared traumatic stress" (Tosone et al. 2014) to depict this phenomenon. The literature is consistent in showing that clinicians risk both primary and secondary traumatization as a result of their double exposure and may exhibit a combination of elements of post-traumatic stress and compassion fatigue. Consequently they are likely to experience both significant negative changes, as well as positive ones, affecting their personal and professional lives (Dekel and Baum 2010; Baum 2013; Lev-Wiesel et al. 2009; Tosone et al. 2014).

Special challenges reported by clinicians to emerge in these situations are related to blurring of various aspects of boundaries between the therapist and the client. Furthermore, the clinicians' inner boundaries between their personal and professional selves may become distorted (Dekel and Baum 2010; Tosone et al. 2012). Therapists may experience a "fearful symmetry" when attempting to handle their patient's anxieties while struggling with their own (Boulanger 2013). They may be confronted not only with intense professional obligations but also with personal concerns that may seem to stand in direct conflict with the demands of their work (Tosone et al. 2014). These changes, although potentially hazardous for therapeutic work, may also have positive effects on the therapeutic relationship. These may be expressed in feelings of a new "therapeutic intimacy", increased compassion and "connectedness" with clients (Tosone 2006). The helping experience may contribute to a sense of professional satisfaction and to personal and professional growth (Baum 2013; Dekel and Baum 2010).

When describing the intense and painful emotional reactions of clinicians while trying to provide intervention following the events of 9/11 in New York City, Pulido (2012) notes that handling children's distress seemed exceptionally provocative in causing anguish for clinicians. Surprisingly, reports on the effects on therapists related to working with traumatized children under the condition of shared trauma, are extremely limited (Figley et al. 2011; Osofsky 2009). This study is an attempt to address this void in the literature.

The phenomenon of "rescue fantasies" of therapists, described early in the development of psychoanalysis (Neumann and Gamble 1995) seems of special relevance to the treatment of traumatized children. Additional countertransference issues, pertaining to therapeutic work with children may become aggravated under condition of a shared traumatic reality, such as the activation and intrusion of the therapist's own childhood memories into the therapy and feelings projected towards the child's parents (Anastasopoulos and Tsiantis 1996; Bonovitz 2009).

Osofsky (2009) observed therapists working with traumatized children exposed to community violence. She notes that the infants' nonverbal behavior and play, or stories told by young children, are so painful that therapists interrupt the traumatic play to "rescue" the child and the family and to ease their own anxiety. This tendency may interfere with the ability to carry out effective therapeutic interventions.

This paper aims to address the experience of therapists working with children under conditions of a shared traumatic reality of war and to learn about the challenges, risks, and positive gains involved in their experience. It is based mainly on analyses of the therapists' own accounts and reflections related to two research questions:

1. How did therapists, exposed to a war, experience their work with traumatized children, both personally and professionally?
2. What were the challenges to the therapy work and the therapists' ways of coping?

Methods

This is an exploratory study in an area that has received little attention, examining reported experiences and reflections. Therefore, it seemed to be most suitably addressed by a qualitative inquiry. It follows strong arguments made for the use of qualitative methodology to study what has been called "the swampy lowland of practice" where one can rarely use control groups and "where operationalising key constructs in behavioral terms is highly problematic…" (Darlington and Scott 2002).

Background

Data were collected from therapists who were engaged in treating school children identified as suffering from post-traumatic distress following the Second Lebanon War in Israel. This war between Israel and Hezbollah forces, operating from Lebanon, broke out in mid-July 2006 and continued until the declaration of a ceasefire in mid-August 2006. During the war more than 4,000 missiles and rockets were fired by Hezbollah towards the Jewish and Palestinian civilian population in northern Israel, causing loss of lives, injuries, and damage to property. Recurrent sounding alarms forced families to spend time in shelters, or to relocate temporarily to safer areas. *Ashalim*, a nonprofit organization for serving families and children at risk, in cooperation with the Psychological Counseling Service of the Ministry of Education, set up a special project to provide psychotherapeutic services to 2,850 children identified through the school systems as suffering from posttraumatic distress related to the war. The project ran from December 2006 through June 2007, employing 70 Israeli therapists, and was later extended until June 2008. The present study seeks to explore the experiences and reflections of these therapists.

Participants

Data were collected upon agreement from the therapists beginning in the summer of 2007 until the summer of 2008. Thirty-three therapists were clinical and/or school psychologists and 37 were art therapists. Their average length of work experience was 10.08 years (SD = 7.3; range 2–35) of employment in the school system or in child mental health agencies. They were selected for part-time employment in the project based on experience in therapeutic work with children and on having received specific training in trauma-focused therapies for children.

Research Procedures

Four different research procedures were utilized to collect data: focus groups, written therapy narratives, interviews and questionnaires.

Focus groups were conducted in July 2007 (about 7 months after engaging in therapy work) in the course of a retreat with 65 therapists, divided into 11 groups. The two-hour group discussions were audio recorded (with the participants' permission) and transcribed. The members of the research team moderated the groups using a prepared protocol presenting the goals of the discussion as learning from the therapists about: (1) the process of identification and referrals of children; (2) work with teachers and with parents; (3) children's needs and best practices of therapy; (4) the personal experiences of the therapists and their impact on the therapeutic work. In this paper we focus mostly on reactions to the two last issues.

Therapy Narratives were voluntarily shared upon request by all 70 therapists at the end of first year of intervention. Narrative analysis is a common tool for qualitative research (Smith 2000). Therapists were invited to share their personal experience of the therapeutic relationship and the treatment process with one child, using a free style narrative rather than a psychological report style. They were reassured that these narratives were being collected for the purpose of learning about the experience of therapists under the unique circumstances of war, and that therefore they need not worry about their writing proficiency. The length of the narrative was restricted to two typed pages.

Phone interviews were conducted with a randomly selected group of 30 therapists who agreed to be interviewed following the end of the analyses of all previously gathered data, during May and June 2008. This timing of the interviews followed recent termination of the therapists' involvement in the project. The interviews were planned as a procedure called "member checking" or "participant validation" (Denzin and Lincoln 2011). This procedure involves sharing the summarized findings with some of the participants. The goal is to find out the extent to which participants agree with the conclusions formulated by the researchers and to further clarify related issues. The interviews were recorded and transcribed and subsequently analyzed.

Background Questionnaires were administered to 65 therapists at the start of the professional retreat. Five additional questionnaires from therapists who did not attend the retreat were received by mail. The questionnaires provided data through open-ended questions related to the therapists' professional accreditation, seniority, type of in-service trainings and frequency of supervision. The questionnaires also included questions regarding the level of satisfaction from the clinical work, and an assessment of the benefits of the therapy to the child, using 5-point Leikert-scales, ranging from 1 (extremely dissatisfied or no contribution) to 5 (extremely satisfied, high contribution). The questionnaires were analyzed using descriptive statistics.

Qualitative Data Analyses

All the qualitative data (from focus group, narratives and interviews) were analyzed by the research team. The focus group material was analyzed through a content analysis of

the answers to the pre-formulated questions, followed by a research team discussion. The interviews and narratives were analyzed from the code level (the smallest unit of meaning), grouped into categories, and then sorted according to the themes that emerged from the categories (Lieblich et al. 1998; Denzin and Lincoln 2011). The narratives were analyzed using three foci: the therapist; the child; and the therapy (including the therapeutic relationship). Each narrative was coded by at least three research team members. Coders discussed disagreements regarding code categories and themes until full agreement was achieved, according to guidelines for coder reliability (Denzin and Lincoln 2011). Given the large number of participants, frequencies were computed for the various major categories of responses. Exact frequencies for responses from the focus groups could not be computed due to their dynamic nature.

In qualitative studies the terms rigor and trustworthiness are used as equivalents to the quantitative terms validity and reliability. Various forms of "triangulation" (comparisons) are considered means for overcoming bias (Denzin and Lincoln 2011) and enhancing rigor (Padgett 1998). In this study three forms of triangulation were utilized: *Method triangulation*-combining several research tools to study the same phenomena; *Investigator (analytic) triangulation*-comparing views of research team members and reaching agreement; *Participants' triangulation*- using "member-checking" (previously described) to achieve a better understanding of analyzed data (Roer-Strier and Sands 2006).

Team Members

It should be noted, as appropriate in qualitative analysis, that all five members of the research team, two faculty members and three graduate students, are Israeli citizens who do not reside in the north and were not directly exposed to the war. However, all the researchers have been previously exposed to collective traumatic events related to political violence. To increase reflectivity ongoing discussions of the data were carried out with local and international child therapy and trauma specialists, not directly involved in the study.

Ethical Consideration

All the procedures used in the study were subject to the approval of the ethics committee at the School of Education of the Hebrew University and approved by the participating agencies. Participants were promised anonymity. A coding procedure was used to protect the identity the described children and of the respondents when collecting and analyzing their materials. All of the thirty therapists approached by phone for the "member-checking" procedure appreciated the opportunity to hear the results of the study and willingly agreed to share their reflections.

Findings

The themes that emerged from the content analysis can be organized in four groups: (1) the effects of the war on the therapists (2) the effects of the therapists' double exposure on the nature of the therapy (3) the effects of the clinical work with the children on the therapists (4) the coping strategies employed by the therapists. For each of the main themes we will first provide a brief summary of the triangulated findings, followed by specific data obtained through each of research methods: focus groups, narratives and interviews, and, when relevant, also questionnaires. The quotes are translated from Hebrew. Since the number of participants varies in the different data sources we use percentages in most reports.

The Effects of the War on the Therapists

The majority of the therapists were directly exposed to the war and experienced high levels of anxiety, stress and post traumatic symptoms. Some suffered grief related to significant losses during the war. Memories of the recent traumatic events intruded into the therapy. Individual non-war related circumstances of various losses exacerbated the emotional difficulties in coping with the war experience.

Data from Focus Groups (n = 65; Groups = 11)

Nearly all the therapists in the focus groups were exposed to the war because they lived in the north of the country and experienced stress; about 25 % of them described unusual personal experiences during the war that involved high risk and extreme anxiety. Many of the therapists continued to suffer from at least some posttraumatic symptoms after the war. An extreme example was provided by a therapist who reported "…I can attest about myself that I have posttraumatic symptoms. I worked in Haifa and a rocket landed near me. Since then and even now I have nightmares. I don't sleep at night. I had abnormal temper-tantrums…" In fact, many therapists remembered that before agreeing to participate in the project they had doubts about their ability to contain the children's traumatic experiences.

Data from Narratives (n = 70)

Although the participants were directed to write a narrative of a child's therapy process, one-third of the narratives

contained spontaneous references to the therapists' own recent personal war experiences, dating back to a year prior to writing, such as: "…I am reminded of the recent war, during which I was in a poor state, I was uptight, my muscles ached, I was under a lot of stress…" Half of these references included lengthy and detailed accounts of war experiences that the therapist recalled during the intervention: "…immediately a picture sprung into my mind of an alarm siren and my husband, children and I running to the shelter…"

Data from Individual Interviews (n = 30)

The interview question was phrased: "From our analysis we got the impression that many therapists were personally exposed to the war experiences and that this may have affected their feelings, behavior, and therapy work. What do you think? If so, what were the effects? How was it for you?"

The majority of the interviewed therapists (74 %) mentioned being personally exposed to the events of the war, the rest were not in the area at the time. Only two of the exposed therapists claimed that they were not affected by the events of the war. Half of those exposed regarded their war experiences as difficult, complex, and even traumatic. A number of therapists used expressions such as "a very difficult time" and "really, really scary." A third of the interviewed therapists reported being affected by personal past traumatic events or losses that surfaced and exacerbated their emotional difficulties during the period of the war, like having recently lost a parent, or being divorced and feeling the weight of being alone in protecting the children.

The most extreme experiences involved dealing with personal losses as a result of the war, as attested by two therapists from different villages: "…Tens of rockets hit my village. My house was hit by one, I had a really difficult time with this…" or "…There were two cases of death in my village as a result of the war. It was very difficult in the village. The most difficult and traumatic thing for me was that my cousin was killed. Now I am reminded of what has happened and you are taking me back there…"

Effects of the Therapists' Double Exposure on the Therapy

The majority of therapists perceived their work with the traumatized children as concomitantly positive and stressful. It activated deep involvement, closeness and warm parental feelings towards the children. The awareness of a shared experience and a common history seen as "common fate" created a sense of better understanding of the children and feelings of identification with their plight. The children's problems were presented as predominantly natural reactions to their traumatic exposure, exacerbated by current unresponsive environments and stressful life circumstances. Therapists reported that the clinical work with the children triggered memories of their own past traumatic events, especially from their childhood. Traumatic contents expressed by the child in treatment tended to evoke anxiety, confusion and avoidance. The therapists preferred to focus on strengths and coping of the children and to avoid dealing directly with their traumatic exposure.

Data from Focus Groups (n = 65)

While many therapists expressed deep engagement in the therapy work, they also admitted that since they had not yet processed their own traumatic war experiences, they may have often felt drained by the therapeutic work: "…We were in a role that required providing ventilation, support, and empowerment. Somehow I felt that there was no room for me. I keep giving and giving and don't receive enough; and somehow I also got sick in the middle of it all—a warning sign! There was no framework to contain me, and after all we too experienced a trauma…"

Data from Narratives (n = 70)

In 95 % of the narratives therapists described their feelings towards the children and the therapy in a detailed and passionate manner. The children were described as "handsome", "cute", "likable", and "sociable." The term "connection" was repeated in 40 % of the narratives, referring to the feelings of a significant, close, and loving relationship with the children. Many therapists described themselves as "touched" by the children, referring to strong feelings of empathy, devotion, and possibly over-involvement: "…her story touched me deeply, it pushed me to be available to her all the time, to take care of her…" These feelings often involved strong identification, frequently connected with the therapists' own past memories. A therapist described her patient: "…so much loneliness, so much loneliness surfaces in me, I am reminded of myself as a child… I feel an urge to make him stronger…" Another therapist shared even stronger feelings: "…During the whole therapy I held the child in my heart and in my head, his pain and his worries…I loved this kid and I loved the treatment and what happened in the therapy room. I will never forget him…" The identification with the child was accompanied in three of the narratives by strong emotions of anger towards the parents: "…in most of my sessions with N I felt angry at the mother for not being empathic with the little one; she did not understand that the child's difficulties were connected to the war experience, and I was also angry at the father for not stepping-in to help her…"

Some of the therapists (17 %) spontaneously included references to the impact of their own traumatic experiences on the treatment. Most of these references imply a positive influence on their professional work, including a better understanding of the experience of the child and of the impact of trauma: "…There is no doubt that my own experiences as a child in a shelter helped me understand the girls in my therapy group and the powerful emotions they experienced…" A few described their identification with the coping strategies of their patients: "…I identified with the need to enlist super-human powers to cope with a reality that is forced upon you…" The identification shifted at times from the therapist as a child to the therapist as a parent, as described by one therapist who had suffered a loss in her past: "…This treatment evoked my own experiences, questions, and traumas. My uncle too died in war when I was a child. This kept re-emerging in my mind during A's treatment. Back to the trauma, to its' severe implications, to the break, and to the scars that such an event leaves with the close ones, forever…the new family conflicts, the depression, anger, guilt…I felt pain and identified both with A (as an adolescent in the past) and with her parents (as a parent in the present)…"

A few narratives (6 %) included specific references to memories of war from the therapists' childhood that emerged during the therapy hours and were especially emotionally laden: "I suddenly remember a particularly traumatic event when I was ten years old. Rockets started landing while I was walking in the street with my friend. We ran into a neighbor's house and hid under a table…This is a thing I will never forget, it was really life threatening…"

Twenty-two percent of the narratives included descriptions of the therapists' confusion and anxiety when confronted with trauma-related materials from the inner world of the child. Some of the descriptions are very emotionally powerful. One therapist recounted: "…During our sixth session S drew one of his typical characters, only this time it was so extreme that I got scared…he drew red patches and said they were blood and gray bones, he actually drew the insides of a body without outer boundaries. This drawing haunted me…" Other therapists similarly described being paralyzed and overwhelmed by the child's products. A therapist wrote: "…I remember my reaction to the child's story. I felt like something hit me from the inside, like a hammer striking my head. I am with her in her pain, frustrated and out of words to describe our mutual experience…"

Data from Individual Interviews (n = 30)

A third of the therapists experienced the resurgence of their own childhood traumatic war memories when reflecting on their clinical work during the interview. The expression "I was a "shelters child" was repeated by a number of them, referring to spending long periods during their childhood sleeping in communal or home shelters through a number of war events. Others recalled incidents from the 1991 Gulf War, when as young adults they experienced feelings of helplessness under the threat of chemical warfare.

When asked to comment on our impressions that the war experiences of the therapists affected the therapy work 77 % of the interviewed therapists agreed and stressed that they were affected both personally and professionally. The main descriptor repeated in most of the interviews was "a sense of common-fate." For example: "…There was a sense of common-fate in the fact that we were all in the North. I did not come from a detached place, like Tel-Aviv, to help the poor people in the North. I knew exactly what they were talking about even without talking; they knew that I was from the same place and that I understood them…"

Half of the interviewees felt that the sense of a common fate contributed to a better understanding of the children: "I could identify with them, be more empathic…it was helpful, I could understand them from the inside…" One therapist expanded on the benefits of a "common-fate," offering an explanation related to the ease of communication in collective trauma: "…In some respects the trauma becomes easier, being able to be told, because it is everybody's experience, the aspect of being individually chosen does not exist here; it is a collective experience. It makes it possible to receive support and sympathy".

An additional therapeutic benefit related to these feelings, mentioned by five therapists, was a very strong sense of commitment towards the well-being of their patients, as reported by a therapist: "…I felt committed to the children, knowing that they are going through things I had experienced…" This urge to "give" was accompanied by "motherly" demonstrations of affection and care. For example, a couple of therapists noted their tendency to express their affection physically: "much tenderness…a lot of hugs…I was infected by lice from the children twice, I was very physical with them…"

A third of the therapists felt that along with the positive effects on the therapy, the experience of a shared traumatic reality had negative effects on the therapist and at times on the treatment. Twenty percent of the interviewed therapists related to the flashbacks of their own past traumatic experiences, aroused by the encounter with the children's traumatic materials, as an intrusive and difficult experience. A few (16 %) alluded to feelings of helplessness, anxiety, and vulnerability, as one of the therapists attested:- "…I felt that although I could feel the experience of my patient, I was anxious, not focused, unavailable. This had a negative influence…"

Seven of the interviewed therapists (23 %) did not claim feelings of a shared traumatic experience, six because they

left the North during the war and moved to a safe place, and one who was in intensive therapy at the time. The therapists who were not in the North during the war expressed feeling guilt for escaping, while feeling "sorrow for the children who remained and had nowhere to go."

Almost all of the therapists reported that their war experiences influenced the way they conducted the therapy. The main influence mentioned by 20 % of the interviewees was choosing to emphasize the coping abilities of the children and their personal resources. As explained by one therapist: "…The message was that 'o.k., you experienced something that felt like your world had collapsed, but we can cope; it is terrible but we will overcome, we carry on, we are here'…" Therapists purposely set out to create in the sessions and in their relationship with the child a sense of a "safe place." They also actively guided the children to create this image in imagination and in artistic expressions.

Therapists described uncertainty about the balance between working through the traumatic memories and the difficult feelings of their young patients, and alternatively, focusing on current resources, soothing, and empowerment. Two therapists were courageous enough to admit in the interview that they realized, in retrospect, that they ignored references to war experience "…I saw the rocket in the child's drawing and understood its connection to the war, but I did not go into it…"

When presented with our impressions that numerous therapists had a hard time initiating or sustaining a trauma-focused treatment the majority of the member checking interview respondents quickly agreed. When asked about possible explanations 60 % tied this difficulty to the therapists' general anxiety. They suggested that the anxiety led to adherence to familiar, traditional, non-directive therapeutic approaches and reluctance to use the newly acquired and more directive trauma-focused techniques. This anxiety also related, according to a number of therapists, to their perceptions of the children as vulnerable and to their own avoidance tendencies. As articulated by one of the therapists: "…There is a fear of making a mistake, of getting into a situation that you won't know how to get out of, you don't know what's inside…"

The Effects of the Clinical Work on the Therapists

The data suggest that therapists experienced high levels of satisfaction from their clinical work with the children. They also reported that the clinical work was at times overwhelming and intruded into their private lives.

Data from Questionnaires (n = 70)

In response to a question about the level of satisfaction from the therapy work in the project the mean rating was very high: 4.26 (SD = 0.74) on a 5-point scale, ranging from 1 (extremely dissatisfied) to 5 (extremely satisfied). They also assessed their contribution to the children as high (Mean = 4.07; SD = 0.68) using a similar scale.

Data from Focus Groups (n = 65)

About half of the therapists in the focus groups reported high levels of intrusion of their work into their private lives, alongside a high level of satisfaction.

Data from Narratives (n = 70)

In the treatment narratives some therapists (6 %) mentioned personal and psychological benefits derived therapist admitted explicitly: "…This therapy gave me a lot, it provided me treatment for my own trauma, and I thank the child so much for that…"

Data from Interviews (n = 30)

The majority of the therapists interviewed reported being affected by the therapeutic work in the project more intensely, in comparison to their ordinary work. As one therapist expressed it: "…It is very difficult to confront these emotionally laden stories and to continue holding both roles: that of a human being facing another human, and that of a helping, supportive professional. It is true for any case, but it is truer in the face of such difficult trauma…"

About half of the interviewed therapists reported high levels of intrusion of their work into their private lives. An additional third of the therapists reported low levels of influence, while only 17 % claimed no such effect. The most affected therapists reported being preoccupied with the children between sessions, feeling at times over-loaded and having intrusive thoughts: "…I keep thinking about how she can cope with such a reality…"; "…It suddenly jumps in when I am physically in a completely different place…" As an extreme example, three of the interviewed therapists reported dreaming about their patients. Three therapists also mentioned that their preoccupation with the patients continued after therapy was terminated.

The Coping Strategies Employed by the Therapists

Therapists reported that the clinical work empowered them and even helped them cope with their problems. Training, supervision, therapy and consultation were seen as main sources of support. Additional resources were prior experience, a balanced work load, peer support, team work, internal resources, self-care, family support, religion and spirituality.

Data from Focus Groups (n = 65)

Therapists in the focus groups pointed out that the process of helping such needy children, in and of itself, helped them cope with their own difficulties. As one therapist declared: "…you get your strength from the children…" The work empowered the therapists by "providing meaning" to their circumstances and allowing them to experience agency and success. Additionally, getting positive feedback from the patients and the school staff and receiving support from the project directors contributed to better coping. Professional experience and intensive training in trauma work were mentioned as important for coping. The majority of therapists acknowledged that their use of supervision was a major source of empowerment both personally and professionally. It helped to overcome difficult emotions and provided wise guidance for managing the cases. Focusing exclusively on the work in the project and being well paid were associated with therapists' sense of well-being.

Data from Interviews (n = 30)

Forty-three percent of the therapists regarded their prior professional experience as an important factor in their ability to contain emotional experiences, maintain perspective, and cope. Thirty-six percent mentioned that the case load and the severity of the patients' trauma had an influence on their coping ability, advocating a lighter load for better coping.

More than half of the interviewees felt that supervision was a meaningful source of coping with their personal experiences and the therapeutic process. One therapist explained: "…I shared much in supervision because I believe that there is only a fine line distinguishing supervision from therapy. I used the supervision to talk about myself and my feelings in the context of the case…" In addition, more than a third found that peer support and consultation, or working in a team, helped them cope, while 27 % of the therapists reported using individual therapy to help them cope. An additional 16 % reported using "self-care" through self-reflection, relaxation practices, writing, and creative art. Family support was mentioned as helpful in coping and "an anchor" by 16 % of therapists, and an additional 10 % mentioned their spirituality and religion as contributing significantly to their coping ability.

When asked about advice to other therapists in similar circumstances, half of the interviewees recommended being in therapy, in addition to using supervision (40 %), peer support and consultation (13 %), and self-care practices (10 %).

Discussion

The picture emerging from the triangulated data sources in relation to the main research foci is very consistent. Almost all therapists exposed to the war believed they were personally affected by the war experience; about half admitted experiencing high levels of anxiety and symptoms of posttraumatic stress disorder. Consequently, the therapeutic work with traumatized children appeared to be highly challenging and significant for all therapists. The therapists were aware of their unique predicament and recognized that the therapeutic work was affected both positively and at times negatively by it.

The therapist-child relationship, characterized by most as "intensely connected", appears to be a key ingredient in the therapy and of great value for both the therapists and the children. The majority of the therapists "risked connection" (Saakvitne 2002) both intrapsychically and interpersonally, finding deep meaning in their work. Danieli (1984) noted in her study of therapists who were survivors, or children of survivors of the Holocaust, that they used the similarity of experience in the service of empathy and understanding of their survivor patients. The therapists in the present study used not only the similarities of their current traumatic collective experience, but also often accessed similar recollections from their own childhood and past histories. Rather than experiencing a "fearful symmetry" reported to often emerge between therapists and their adult patients in collective trauma (Boulanger 2013), these child therapists experienced a sense of "parental" responsibility to safeguard the children's well-being. The special therapeutic relationship may have provided the children with a protective shield of empathy, support and dedication. These components are considered among the most important in promoting children's resilience in coping with war or community violence (Garbarino 2001).

By facing fears together with their patients, therapists reprocessed feelings of helplessness and experienced helpfulness and worthiness, recognizing that they are needed by their clients. Lev-Wiesel et al. (2009) similarly found in a sample of social workers and nurses (who, like our therapists, worked in the shared reality of the same war, albeit with adults) that having to be responsible for others enhanced their sense of being needed and trusted, and contributed to posttraumatic growth. This may be even more intense in working with children.

A new concept that emerged from the therapists' descriptions of the therapeutic relationship is "a sense of a common-fate." This concept is similar to the concept "shared traumatic reality", yet it refers to the more comprehensive concept of "fate" rather than merely "trauma". This may possibly reflect the therapists' sense of being

survivors, and repeatedly so, rather than victims. This notion is further reflected in their emphasis on coping and resources during the therapy sessions, in keeping away from viewing the children in pathological terms, and in the affective interweaving of memories of their past traumatic experiences with those of the children. As therapists became more aware of their own history of recurrent war experiences during their exposure to their patients' traumatic experiences, the sense of participating in a community struggling with a history fraught with collective traumatic events may have intensified the sense of "fate" shared by the therapists and their communities.

The sharing of the same group characteristics such as religion and nationality further enhanced the feelings of intergenerational identification and cohesion. "Weeping with the child" in therapy, described by one therapist, and other types of intense emotional identification reactions described by others, may thus also reflect, beyond the pain of shared trauma in the present, the painful realization that yet another generation of children of the identified group is being exposed to war and political conflict. Interestingly, the small number of therapists who did not claim experiencing a "common-fate" with their patients, mostly because they relocated from the war area, felt guilty for being spared what others could not avoid, thus paradoxically proving the sense of expected partnership in fate.

These feelings of intergenerational sharing of traumatic experiences between both the present and past experiences of the therapists and those of the treated children have proven at times to be problematic. They may have caused the therapists to project their own feelings onto the children and to cause confusion between self and other. Ornstein (2013) emphasizes the importance of recognizing individual differences in cases of adult therapy, when a common background of collective trauma could obscure important differences in the personalities of the therapeutic dyad. Danieli (1984) further points out the possible defensive use of the similarities in traumatic experiences to foreclose the expression of the patient's traumatic experience. This may interact with the patient's own fears of reliving the trauma when sharing it, thus leading to "a conspiracy of silence". Our findings show that such dynamics have occurred in the treatment of the traumatized children.

Some of the therapists' own reflections attest to the risks of therapeutic "lapses of empathy" (Baum 2013), diminished emotional availability and use of avoidance to defend against the anxiety evoked by the children's expressions. Therapists tended to avoid dealing with their clients' painful traumatic memories by ignoring the children's symbolic references to them, or directed the interactions with the children to focus on the present and on strengths and problem-solving. This may have protected the therapists, but probably left some of the children, who read the non-verbal avoidant communication of the therapists, isolated with their fear and anguish. Indeed, in a number of narratives therapists described the child sharing his or her traumatic war experience only during the last therapy session, a phenomenon suggesting the therapist's failure to facilitate the child's wish to share the story at an earlier point during the therapy.

While only a small number of therapists may have become aware by themselves of their avoidance, mostly in retrospect, and reported it, the scope of the phenomenon may be much wider, since it is often unconscious. Since maternal avoidance of trauma-related materials was found to be related to diminished adaptation of their children years after the collective trauma of war (Laor et al. 2001) therapist avoidance may involve a similar risk.

The evidence for the efficacy of exposure therapies (Foa et al. 2009; Gilboa-Schechtman et al. 2010) raises questions as to the reported avoidance of such techniques by some of the studied therapists due to their level of anxiety. Yet, there is also evidence for benefits resulting from present-centered approaches in the treatment of traumatized children, involving symptom management, problem-solving techniques and coping skills similar to those used by the studied therapists. These may be seen as contributing to the children's self-regulation abilities. The importance of supporting the development of self-regulation skills in children in the face of traumatic exposure is being emphasized in the recent literature (Pat-Horenczyk et al. 2014). The therapeutic alliance, considered as most significant by the therapists in our study, is also found to be of paramount value when implementing any treatment for clients suffering from posttraumatic distress (Foa et al. 2009) and especially in working with complex cases of traumatized children.

Working with children under the conditions of a shared traumatic reality was not without considerable negative effects on the quality of life of the therapists. About half reported powerful emotional reactions to the experiences shared by the children verbally and symbolically, that intruded into their personal lives, suggesting VT. The revival of childhood recollections of traumatic events during the therapy sessions took many of the therapists by surprise. This is an important yet under-reported phenomenon in the trauma treatment literature.

In one of the rare discussions of this phenomenon in the more general literature of child psychotherapy, Bonovitz (2009) claims that this countertransference phenomenon is rather natural and frequent in child analysis. Countertransference in therapy with children may involve several types of internalized object relations and present roles: the inner "child" who was or was not recognized; the idealized parents of the therapist and the punitive critical parents; the present role of the therapist as a parent; and the therapist's

own children. We believe that this is particularly relevant to trauma work, even if it is not analysis, but rather short-term therapy. In spite of expected conflicting loyalties between familial and professional roles, the therapists in this study clearly chose to commit to their professional world, as did therapists in the south of the country, according to Dekel and Nuttman-Shwartz (2014). In the present study, therapists wished to integrate their personal and their professional preoccupations, by attempting to become an ideal parent to their young patients: providing safety, eradicating fear, providing physical comfort, feeling love, and being preoccupied with the child, while being critical of the child's parents for not being affectively attuned. It seems that the therapists' sense of parental responsibility, protectiveness and concerns about doing no harm, may be heightened with child patients, as compared with adults (Bonovitz 2009) and even more so in situations of shared trauma. As formulated by Warshaw (1996) "…The desire for control in order to defend against the terror of utter helplessness, the need to reestablish stability, and the wish to recreate a childhood illusion of safety are all powerfully present in the psychic world of the person who has experienced trauma…" This seems to be true for both the treated children in our study and for their therapists.

Therapists claimed that the satisfaction derived through the therapy work itself was a major resource for their coping. Additional coping strategies employed by the studied therapists which they found helpful in dealing with their multiple sources of posttraumatic distress involved mainly the use of interpersonal support networks for psychological processing of complex experiences. Although various self-care practices were also employed, they were viewed as less important than psychotherapy, supervision, peer support, and consultation. This hierarchy of recommendations is different from those reported in other studies of trauma work with adults (Harrison and Westwood 2009; Horrell et al. 2011). This may reflect the therapists' awareness of the risk of VT under conditions of a shared traumatic reality, especially in working with children, a population potentially evoking more intense emotional involvement and concern.

Study Limitations

Although this study is based on a large data set, according to the norms of qualitative research, readers should use caution in generalizing the results. The special circumstances and context of traumatic events are always unique and affect the findings. The presented data are all based on the reports of the therapists. These may have been colored by social desirability or by perceiving the study as a sort of evaluation.

Summary and Implications for Research and Clinical Work

It appears from our study that working with children under circumstances of a shared traumatic reality is particularly challenging, and involves both high levels of posttraumatic distress as well as high level of work satisfaction. It was characterized by the majority of the 70 studied therapists as involving an intense emotional engagement with their young patients. The perception of an intergenerational "common-fate" between the therapists and the children often contributed to increased empathy and the forming of an intimate, care-giving relationship. The therapy work, which focused mostly on emphasizing the children's strengths and building strategies for coping, provided the therapists with a sense of agency and helpfulness and may have served often as a protective measure against both primary and secondary traumatization. It further provided the therapists an opportunity to rework their own traumatic childhood memories that tended to emerge while they were engaged in child therapy. Concurrently, posttraumatic distress experienced by the therapists due to their own recent war exposure and past traumatic events seemed to present a potential barrier for their therapeutic availability, and to have led to a defensive avoidance of the children's painful traumatic memories. VT related to witnessing the children's accounts of their traumatic experiences also seemed to exacerbate the level of distress of the therapists, outside the therapy hours.

Advance preparation of therapists about the likelihood of VT during therapy with traumatized children and advance dealing with the possible emergence of personal traumatic memories, involving both recent and past traumatic events, is recommended. A history of potentially traumatic life events that were adequately processed can serve as a source of therapist's resilience (Tosone et al. 2014). Training in trauma focused therapies may become useless without this preparation. Furthermore, the monitoring through supervision, peer consultation, and at times personal therapy, of the natural experiences of blurred boundaries between the personal and the professional, self and other, may ease much of the therapists' distress in encountering these phenomena. It may raise their awareness when these feelings interfere with the process of therapy by leading to avoidance of children's materials and foreclosure of their communications.

Overall, most therapists considered their work to be beneficial to their patients. Such subjective evaluations need to be examined in future studies in the context of independent evaluations of therapy outcomes, and also linked to the levels of distress experienced by the therapists. Also, further research is needed in order to decipher the commonalities and differences in the dynamics of

trauma work under conditions of shared and non-shared traumatic realities, especially in trauma work with children.

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