The Traumatic Process: Conceptualization and Treatment

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Abbreviations:
ASD = acute stress disorder
BPD = borderline personality disorder
CISD = critical incident stress debriefing
DID = dissociative identity disorder
DSM-IV = diagnostic manual of the American Psychiatric Association
PTSD = post-traumatic stress disorder

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Abstract

Traumatic stress stems from a threat to an individual's or a group's very existence. The impact of the existential threat may be compounded by an inability to cope, which affects the perception of helplessness and loss of lawfulness. A model is proposed in which the traumatic process is conceptualized to develop through three stages: (1) alert; (2) impact; and (3) post-trauma. In this model, treatment of traumatic stress emphasizes the need to control and expand life, and to achieve lawfulness and meaningfulness. In the proposed model of treatment, there are essential differences at each of the stages of the traumatic process: (1) primary prevention at the stage of alert focuses on planning strategies for coping; (2) secondary prevention at the stage of impact is based on forward treatment and debriefing; and (3) tertiary treatment at the post-trauma stage attends to coping with internal chaos and arbitrariness.

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Definitions

Stress, Crisis, and Traumatic Stress are Three Different Entities

The terms stress, crisis and traumatic stress have been used interchangeably and confusingly at times. It is important to succinctly define each of these terms before embarking on a more detailed account of each.

Stress

Hans Selye appropriated the term stress from the field of engineering and applied it to biology and mental health.[1,2] He discussed and researched stress as arising from situations in which the organism faces an external threat. Lazarus further developed some of Selye's concepts, focusing mainly on the human process of coping with stress.[3,4]

Stress is the tension felt internally by an organism when an external threat (stressor) disrupts the normal course of life, requiring some actions of coping in order to regain homeostasis.[1–8] When an adult faces a threat, one must go through an appraisal process of evaluating the realistic essence of the risk involved, while sifting out imaginative and irrational attributions. At the same time, the person evaluates possible ways of coping, inner resources, and potential help and support from trusted others.[3–7] Younger children often are unable to assess the threat and resources even in a simple stress situation. They need translation, interpretation, and support from adults. In a similar vein, a threat to an entire community or nation requires complex coping, as the individual is dependent upon the government leadership for this process of evaluation and guidance.

Many studies suggest the central role of leadership and support in stress situations.[9–11] A nine-year longitudinal study investigating the influence of

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stress and support on mortality, found that individuals who experienced stress without support sustained significantly greater mortality than did those who experienced stress with support or no stress. When in times of stress, leadership is absent or ineffective, social networks and supports diminish, and the members of the group are likely to display emotional disorders.[5-6,9]

Some forms of stress endanger the organization and structure of communities, leading to an increased risk for members of those communities. Under sufficient assault, a state may disintegrate and become unable to defend its citizens against an external threat. Effective leadership can prevent or help reduce mental distress and illness by channeling the response of individuals towards coping behavior. This also is true for emergent leaders as well as for nominated figureheads.[7-9,12,13]

Crisis

The term crisis can be traced to ancient times. Erich Lindemann developed the modern usage of the term,[14] and Gerald Caplan deepened its theoretical framework.[15] Their initial formulations defined crisis as a sudden and acute break in the developmental process. The treatment, crisis intervention, was a short-term therapy that was considered a better interventional approach than was long-term therapy for developmental difficulties. A developmental disorder is a disturbance stemming from within the personality, based on an internal conflict and causing temporary developmental arrest or a permanent halt in psychological growth (fixation in Freudian terminology).

Traumatic Stress

Among many possible stressors (migration, unemployment, illness, etc.), there are some that are more likely to lead to traumatic stress situations, such as rape, child abuse, combat trauma, natural disasters, and terminal illness. The commonality among them is a threat to the individual's existence.[16] When coping with a traumatic stress is not successful, the person is flooded with intense feelings of helplessness, rage, and resentment at the apparent or actual arbitrariness of events. In some people, these feelings may return sporadically for an extended period and sometimes for life, typically as images, feelings, somatic sensations, etc.[5-8,12,17-23]

The devastation of large-scale trauma is not confined to individuals alone, but also may destroy the social structure and order. This is seen in wars, where the intention is not to kill all of the enemy's soldiers or civilians. Wars are won by breaking the spirit of the enemy, its social structure and leadership, and its determination to go on. The dismemberment of the social structure and lack of leadership contribute to the high prevalence of psychological casualties in the citizenry.[7-9]

Confusion of Terms

Over time, the distinction between the terms stress, traumatic stress, and crisis have become hazy, and professionals have used these terms synonymously. Some authors specifically indicate that they deal with both stress and developmental crisis, but do not make distinctions between these terms/concepts.[24,25] Others define their work as dealing with crisis, but exemplify this by cases taken from stress-eliciting situations.[26] Only a few authors have been consistent with the Selye/Lazarus definition of stress, and use the term crisis in the context of its proposed meaning of developmental crisis.[14] However, there are both didactic and treatment advantages in being clear about whether one is dealing with developmental issues, or with disruption to the client's life by an external threat.

Stages of Traumatic Stress

Traumatic stress situations, such as disasters, consist of three stages: (1) alert; (2) impact; and (3) post-trauma. However, these stages appear independently only in a short, simple trauma, i.e., a time-limited, single-episode event. In a complex or prolonged trauma, the stages may appear simultaneously. For example, a child who is abused by one's parents may be in the post-traumatic stage because of past abuse, but at the same time, the abuse is ongoing in the present, and it is expected that more is to come. Thus, the unfortunate child is in all three stages simultaneously. The same lack of differentiation is characteristic of continuous terror. While a community is dealing with past trauma, it may be on the alert for another attack. In such situation, it is important that treatment efforts focus on the most important aspects of the trauma, and less crucial components left for later treatment.

1. Stage of Alert

The stage of alert pertains to a period in which one is aware of a potential threat, but the danger has not yet materialized. In this stage, anxiety mounts, and individuals are motivated to learn about the nature of the threat, and produce strategies for dealing with the threat. These ideas may escalate into individual and organizational planning, prevention programs, and coping strategies. The pathological response in this stage is denial of the threat, which hinders the necessity to plan for the threat. Treatment is focused on the prevention of helplessness.

2. Stage of Impact

The stage of impact refers to the period when the threat materializes, and shortly thereafter. In this period, active coping is necessary for survival. This stage can be short or long depending on external factors, namely the continuation of the stress.

The diagnostic manual of the American Psychiatric Association (DSM-IV) includes the category of acute stress disorder (ASD), defined by exposure to a traumatic event, presence of dissociative symptoms (i.e., numbing, reduction in awareness of one's surroundings, feeling that the event is happening or has happened to someone else), persistent re-experiencing of the event, avoidance of stimuli that remind one of the event, and prominent symptoms of anxiety or hyper-arousal.[27] The ASD and post-traumatic stress disorder (PTSD) are the only DSM-IV diagnoses that identify exposure to a traumatic event as etiological criteria. The diagnosis of ASD is applicable to individuals

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manifesting these particular trauma symptoms during the stage of impact.

However, clinical presentations vary greatly during this stage. Responses to trauma may take on somatic, emotional, or behavioral forms. Often responses and symptoms in this stage are elusive and change rapidly.[28,29] Somatoform responses can include a mimicking of the effects of an anticipated physical trauma, even if the person had not been physically hurt. For instance, people who believe they were exposed to chemical or biological agents may exhibit the physical manifestations of exposure, such as blisters on the skin, breathing difficulties, etc.[30–32] In extreme stress, trauma may be expressed in other somatoform ways, as well as by dissociative amnesia, or fugue (sudden flight away from one's home or work, with amnesia about one's past).[5–7,33–35] Essentially, one can observe either hyperalertness and emotional swings (fight or flight), or a freezing response with numbness and dissociation. The common issue for each of these reactions is the experience of not being in control of one's actions.

3. Post-Traumatic Stage

The focus of this paper is on the post-traumatic stage, which starts some time after the threat has subsided, primarily when coping was not successful or inadequate in relation to the extent of the stress experienced. Psychological problems in this stage stem from failure of adaptation in the stages of alert and impact, and the consequent sense of helplessness in the face of the threat to the life, security, or well-being of self or others, especially those loved or known. The post-traumatic stage is characterized by attempts to adapt to internal changes in personality structure brought about by the traumatic experience. Cognitive, affective, and somatic defense mechanisms are developed and take the place of the original freedom and flexibility in functioning.

In adults suffering from simple trauma, the most dominant clinical picture at this stage is PTSD.[12,16,18–21,36–37] However, research indicates that PTSD is not the only syndrome that can occur in the post-traumatic stage. Other symptoms/disorders in response to trauma that are described in the literature are detailed in the following sections.

Dissociative Disorders

Dissociation is a defensive fragmentation of the personality aimed at minimizing pain through a disruption in the normal integration of conscious awareness, memory, and identity.[38–41] Barriers are created between parts of the personality in order to curtail the flow of painful emotions and memory. However, this process results in an inability by the individual to comprehend the total picture of the traumatic experience. The prevailing knowledge among experts on the post-traumatic process is that dissociative disorders usually are the result of trauma.[17,23,28–33,38–42,43]

Hypervigilance

Hypervigilance is typical in persons who have experienced trauma. Its main manifestations are startle reactions to sudden noise, and the ongoing expectation of another disaster. This reaction is tied to physiological over-arousal based in part on the collapse of the sense of order and lawfulness, and the constant expectation of another trauma. While hypervigilance may be a component of the PTSD, it also can be a syndrome in itself.[27]

Somatoform Disorders

Somatoform disorders are characterized by pain and other somatic sensations that are particular manifestations of the dissociative defense against the traumatic memory. The fragmented memory is converted to bodily sensations, and is not accessible to mental or emotional processing. When the traumatic memory surfaces, it does so through the body, while emotional and mental processes remain numb. Some somatic sensations may symbolically express the traumatic experience. Historically, for this category, Freud used the terms Hysteria and Conversion Disorders.[33–35,43]

Panic Reactions

Panic reactions also can reflect a dissociative reconstruction of the traumatic experience, in which the surfacing traumatic memories are experienced emotionally and somatically, while the cognitive memory is inactive. People who process the trauma in this dissociated manner often may be unaware of the fact that they are re-experiencing a past traumatic experience. Therefore, in trying to explain their emerging sense of helplessness, they are inclined to attribute it to signs of an impending heart attack, suffocation, or imminent psychosis.[43–48]

Phobias

Phobias frequently occur in the post-traumatic stage, and are a special case of avoidance of stimuli that elicit the memories and emotions associated with the original trauma.[43–45,48–50]

Reactive Behavior Disorders, Alcoholism, and Drug Abuse

The violent or anti-social behavior in this group of disorders may be a behavioral reliving of the traumatic events suffered by the individual, or a defense against feeling the pain. Soldiers may manifest disciplinary and conduct disorders under stress, while children often act out the trauma through negative behaviors directed against other children.[14,28–31,51] Substance use can serve as an avoidance/numbing function in relation to thoughts or emotions associated with the trauma.

Depression, Pervasive Guilt

Depression and a pervasive sense of guilt are typical reactions by survivors of trauma. The survivors' guilt usually is irrational. It does not denote any wrongdoing, but rather is a defense against a sense of helplessness and arbitrariness. If one feels guilty, there is an inherent sense of order, which is missing for the survivor.

The Post-Traumatic Reaction

Typically, adults with no previous history of trauma who have experienced a single-episode, extreme event (simple

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trauma) tend to recover without professional intervention. Some develop an ASD, and a few go on to develop the PTSD, i.e., if specific symptoms last for more than one month. Recovery from PTSD is quite possible, either spontaneously or with professional help. However, a minority of the survivors may develop a chronic reaction to trauma, which may linger for life and cause much debilitation.

Children are less inclined to react with the development of the PTSD, and are more likely to exhibit a range of dissociative symptoms, behavior disturbances, and a failure to function adaptively in their social and psychological tasks. The younger the child is at the onset of the trauma and the more repeated or longer its duration, the higher is the risk for a compounded disturbance. This disturbance is categorized as a complex trauma, and includes personality disorders along with dissociative reactions.[20,22–23,30,52] At a future time, the most severe of these compounded disorders may lead to dissociative identity disorder (DID), formerly termed multiple personality disorder,[38,41] or borderline personality disorder (BPD).[42]

The most serious long-term outcome of traumatic stress situations is a seemingly permanent post-traumatic disorder characterized by a collapse of that internal cognitive schema that enables a sense of trust, order, lawfulness, and a sense of control over the world and oneself.[36–37] In individuals who were exposed to trauma from early childhood onwards, the development of this schema may have been stunted.

Post-traumatic reactions can be manifested by any or all of the symptoms listed below. These symptoms may occur continuously on a daily basis or sporadically, and may be dominant or marginal.

1. Viewing the world as arbitrary and harsh, and perceiving the self as helpless, sometimes leading to a style of life typified by helplessness.
2. Frequent intrusive imagery and thoughts related to the traumatic experience, and at the same time avoidance of stimuli that may trigger the memory of the trauma. Social withdrawal may be an extreme consequence of the avoidance tendency. The recapitulation of the traumatic experience may be total, involving all faculties, or it may involve dissociative, partial memories. The latter may arise through one sense only, such as visual, auditory, or somatic sensations.[8,17,19,27–28,32–34,41,42,52] The symptoms of "intrusion" reflect the ongoing reconstruction of the traumatic experience. These symptoms actually may be a part of the healing process rather than a symptom of psychopathology, providing that the reliving experience is not so intense as to bring about a sense of re-traumatization, clearly not conducive for healing. In the latter case, the survivor then may perceive the sense of helplessness as a reaction to a current external threat, indicating an actual risk for personality disintegration, rather than a recollection of past memories. The ability of the survivor to distinguish between helplessness stemming out of memories and helplessness that is a reaction to present stimuli is a crucial step in the healing process.

Basically, both dissociation and compulsive re-experiencing of the traumatic memories typify the post-traumatic reaction. While the aim of dissociation is to minimize pain, in doing so, it causes an inability for the individual to comprehend the total picture of the traumatic experience. Complementarily, the compulsion to revisit the traumatic experience in images, feelings, somatic sensations, and the like, facilitates the flow of emotions and enhances the comprehension of the overall picture, while increasing the sense of helplessness and pain. The tension between these two opposing forces is at the heart of the post-traumatic reaction.

In my experience as a clinician, all post-traumatic reactions contain some aspects of dissociation, i.e., splitting among parts of the self and obstruction of effective communication among the parts (such as in DID). In different individuals, barriers are erected among input/output routes of the survivor's personality. There is a limited interaction and dialogue among feelings, thinking, somatic senses, etc. (such as in BPD). The internal barriers and splitting of feelings and thoughts also are essential constituents in understanding the nature of the post-traumatic reaction. These processes exist in varying degrees in any post-traumatic reaction. In some individuals, it is a minor addition to PTSD; in others, it is the primary clinical presentation.

Standard of Prevention and Treatment in Traumatic Stress

The central principle in the prevention and treatment of traumatic stress is to guide survivors towards adaptive coping in order to prevent helplessness and maintain equilibrium and control. In the beginning of the traumatic process, at the stages of alert and impact, the emphasis is on adaptive planning and coping behavior in order to avert the threat or minimize casualties. In the post-traumatic stage, the focus is on psychological adaptation, regaining the sense of control, order, and lawfulness. Psycho-education, i.e., helping people to accept their responses as "normal" reactions to an abnormal event, is an important ingredient in the therapy and prevention of a chronic post-traumatic reaction. Understanding and accepting this concept of normality is conducive for engaging in coping behavior.

In all stages of the traumatic process, the primary therapeutic objective is preventing or ameliorating helplessness, rather than simply reducing anxiety. Anxiety is to be channeled toward coping. Just as with pain in the body, anxiety is a warning signal for the psyche to alert the person and mobilize him/her for action against a perceived danger. We do not wish to kill the messenger, but rather utilize this affective experience for coping: to order thinking, learn about the threat, and acquire tools for coping. Attempts to pacify a person or a public under stress may prove to be iatrogenic, since pacification reduces the urge to plan coping strategies and encourages denial. Table 1 summarizes the type of focal intervention applied at each stage of the traumatic process.

In the prevention and treatment of traumatic stress situations, it is vital to emphasize attributions and behaviors of health and strength. Clients after trauma as well as people under threat function better when they perceive themselves as coping effectively, and not as helpless. The self- or other-imposed label of victim or illness may encourage pas-

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Stage	Focal Treatment
Alert	Primary prevention programs Guidance in planning strategies for coping
Impact	Secondary prevention Building support and coping Models: Forward treatment of soldiers Debriefing
Post-Trauma	Cognitive, behavioral, and emotional processes geared to support coping

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Table 1—Type of focal treatment in each stage of the traumatic process

sivity and the expectation of external help, which discourages adaptive coping.[5–8]

Prevention at the Stage of Alert

At the stage of alert, there essentially are no casualties to be treated. Therefore, the only meaningful activity/treatment is primary prevention. However, in a large-scale threat such as terror or war, everyone potentially is a future casualty. Therefore, it is important in this stage to launch prevention programs that are designed to minimize both physical and psychological casualties. This is attained either by neutralizing the threat itself or by assisting the population at risk to bolster their resources for coping with the threat. It is vital for the general population to learn the realistic components of the threats and its limitations.

Enhancing vigilance and awareness as well as planning national and personal strategies for future coping is an effective mode of prevention of later problems. At this stage, it may be iatrogenic to attempt to curb anxiety in the affected population. It is preferable to channel the fear into alertness and planning rather than to pacify fear and risk the development of denial.

Secondary Prevention at the Stage of Impact

At the stage of impact, the threat already has materialized, and effective behavior involves coping in order to survive. Leaders are expected to organize active coping according to pre-planned strategies. Further, survival is enhanced primarily by taking action rather than by psychological processing. This is an essential point in the understanding of treatment at this phase.

During this stage, most people can be expected to cope successfully. Many, however, may be on the verge of severe psychological distress. Some in the latter group can be expected to struggle to adapt, especially as their resources dwindle; such people will need support to avoid their total psychiatric/physical disintegration. Others may be objectively defined as casualties, but actually may be in a conditional state that will be reversible if treatment and support are given promptly. The stage of impact often leads to a state of negotiation within each person or between each person and the social system, about whether to endure and cope adaptively, or to succumb to the stress and be defined as helpless victims.[5–8,28,53]

Therefore, the best approach in this stage, is a combination of secondary prevention and immediate treatment. The aim is to strengthen both individuals and the group in order to promote coping with the stress and prevent people from being overwhelmed by its effects. In the effort of empowering individuals and the group, the conduct of the leaders, whether appointed or emergent, and group support are crucial.[5–9,13] The group must stay together in order to maintain close ties with the leadership and the social support network. Dismemberment of the group as a consequence of stress, or separation of a member from the group for similar reasons, may cause the individual to feel lonely and unsupported against the threat, thus leading to the point of severe psychological distress.

During the stage of impact, the essence of treatment is guidance in active coping rather than psychological processing. Emotional expression is allowed, as it may assist in the process of understanding what is happening. But it cannot replace action designed to protect lives. In this stage, processing the sense of helplessness is not appropriate. Instead, leadership to promote guidance aimed at survival is more effective in instilling a sense of control and preventing feelings and behaviors of helplessness.

Treatment Models

The literature offers two treatment models that have been used in the stage of impact: forward treatment in combat and debriefing. The model of forward treatment aims at returning soldiers who have succumbed to combat stress to prompt resumption of active coping and rejoining their comrades as a group, the latter being best able to support them at that time.[5,6,10,54–58] The debriefing model developed by Marshall aims at preserving the group by reconstructing the traumatic events (rather than feelings) within the organic group immediately after the trauma.[59] A variant termed Critical Incident Stress Debriefing (CISD) that focuses on emotional processing was devised more recently by Mitchell,[24,25,63] and is widely used in the United States as an immediate group intervention for rescue workers and others experiencing disaster and terrorism events. (Concerns about the efficacy of CISD are considered in a later section of this paper.)

The forward treatment and Marshall's debriefing procedures were established to treat soldiers at the stage of impact, but their principles are applicable to some civilian trauma situations as well, particularly when the conditions are similar, i.e., when an organic group is faced with a threat and must endure it as a group. Both models are based on the assumptions that adaptive coping at the stage of impact is best carried out in the immediate vicinity of the trauma by dealing with the real threat (civilian or military), and that coping behavior prevents helplessness and post-traumatic sequelae. Also, both aim to preserve and promote the type of leadership and intra-group support that prevent later illness among the group members. Resilience is fostered indirectly by advocating effective coping behavior and by enhancing the two most crucial

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preventive factors in times of combat: leadership and social support.

Another aspect inherent in both models is the acceptance of emotional reactions and symptoms (anxiety, helplessness, night terrors, etc.) as normal in an extreme situation. For this reason, at this stage, there is no need for either emotional processing or interpretation and trauma counseling. Actually, the latter may cause psychological damage at this point in time.

It is noteworthy that at the stage of impact, people still feel immersed in the threat. Therefore, coping is geared towards minimizing the threat or enhancing inner and external resources for coping. Social support, leadership, and self-perception of normality and the ability to cope are crucial for actual effective coping and for preventing future post-traumatic reactions.

1. Forward Treatment Model

Forward treatment of soldiers was created in World War I by the American Psychiatrist, TW Salmon, who based it on observations of the British and French armies.[54,55] Forward treatment is immediate, performed in geographical proximity to the frontline and the organic/essential unit, and utilizes clear, authoritative messages that convey the expectation of a prompt return to combat duty in one's unit. Therapists provide for primary needs, like food, drink and sleep, as necessary, and then refer the soldier back to the combat group. This prevents combatants from labeling themselves as helpless, because they have resumed adaptive coping and received the support of the group that is most meaningful to the soldier at that point in time. Treatment does not focus on feelings and does not attempt to elicit them, or to reconstruct the traumatic events. It is important to bear in mind that at this stage, priority is given to dealing with the threat itself and trying to minimize its devastating effects. Failure to do so may create intense guilt later.

Forward treatment strengthens the organic unit (military, fire department, police, and school class) by minimizing its dismemberment. In return, the group strengthens the individual. This author contends that in this stage of the traumatic process, reconstruction of equilibrium and health is attained most effectively by the combined effects of support, leadership, and coping, rather than by psychological counseling. This contention is supported in the research literature.[5,6,57,58]

2. Debriefing Model

Debriefing was developed by Marshall during World War II. The aim of debriefing as initially formulated, is to strengthen the combat unit through group discussion in which events in the battle are reviewed and updated. Thus, everyone receives a fuller and more accurate picture of the battle, rather than a fragmented view.[59,60] The discussion does not try to elicit feelings. The question is "what happened?", and not "what did you feel?" However, when feelings are expressed, they are accepted with dignity and without psychological interpretations, as normal expressions in a state of stress.[66] This simple sharing and acceptance of feelings within the group can enable normalization of the intensity of feelings and symptoms, and promote mutual bonding.

Interpretations and emotional processing may divert the inner energy from active behavioral coping, only to create later guilt for having betrayed one's comrades. Therefore, trauma counseling should not be used in debriefing. Interpretation of symptoms, encouragement of emotional processing, and a systematic trauma reconstruction all belong to the post-traumatic stage. If these activities are carried out in the stage of impact, the result may be a dilution of the focus on active coping. The fact that the critical incident stress debriefing (CISD) focuses on emotional processing in a group setting immediately following a disaster or terrorist event can be iatrogenic because individuals are not psychologically ready at the stage of impact to deal with these feelings. They still are in the mode of active coping with the external threat. Furthermore, the particular group must continue to work together; however, individuals with highly debilitating difficulties can be referred later for post-traumatic treatment.

Recently, the debriefing model has come under severe criticism.[60–62,64–67] However, when negative sequelae occur, it appears due to the inappropriate utilization of post-traumatic tools and models in the stage of impact. Carlier critically reviewed the debriefing model, procedures and indeed, described debriefing as an attempt to prevent post-trauma by prematurely processing the trauma.[61] Her doubt in the efficacy of the method is understandable. When inappropriate concepts and processes are used, it is reasonable to point to the potential for damage. Moreover, some studies used "debriefing" in an individual context after trauma; however, the concept and procedures were established for application in an organic group setting.[59,62]

This following description focuses on the debriefing procedure developed by Marshall and as used later by the Israel Defense Forces.[59,66] The experience of stress naturally creates tension and anger among the members, which also can place trust in the leadership at risk. Because unit cohesion and mutual support and trust in the leadership are vital for the preservation of the group and crucial in preventing illness among its members, these factors must be supported and strengthened. Group togetherness, and the ability of its constituents to receive/understand the full picture of what has happened, function primarily to strengthen the ties among the members and trust in the leadership. Mitigating anger and bolstering trust to accomplish this, for example, through understanding that one's comrade or commander did not help the traumatized individual because he himself was rendered helpless at the time, or had to engage in support for someone else. Such discussions are not meant to process the trauma. However, the prevention of trauma may be an indirect result. Further, there is a role in Marshall's debriefing for recognition of the achievements of the group, the special efforts of some, honoring the casualties, and focusing on the lessons learned. All of these support the group and its leadership.

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A debriefing discussion may end with orders and planning for the future. As much as possible, the natural leadership should lead the discussion, rather than outside professionals. Mental health experts may be auxiliary to the leader and intervene minimally.

This kind of prevention easily can be transferred to any organic group.[67] When conducting debriefing with young children, it is advisable to add other dimensions to the verbal discussion, such as arts, drama, and play. When carried out within the context of the group, such exercises help to improve reality testing and normalization of responses. Leaders may participate and share their feelings as a way to model that such expressions are legitimate. Feelings are merely acknowledged, respected, and normalized.

With children, it also is suggested that values, such as bravery and coping, be clarified while focusing on the exact meaning of the terms. Young children often have distorted views of words or concepts, which obstruct the healing process. Learning that fear is not a negative term, and that brave people overcome their fear and act rather than act without feeling, is helpful. This kind of understanding promotes normalization of the children's own state of mind: In a school class, it also is suggested that the discussion ends with suggestions for active coping.

In summary, both Forward Treatment and Debriefing as developed by Marshall are models of treatment and secondary prevention that are suited for the stage of impact in both civilian and military trauma. Forward treatment regards the soldier as basically healthy and able to endure. Likewise, debriefing aims at restoring the strength of the group in order to indirectly support and empower the individual members.

Treatment of the Post-Traumatic Stage

Survivors of trauma have emerged from a situation in which they had experienced helplessness in the face of a threat of annihilation.[14] This horrid experience may have undermined, possibly to the point of collapse, the structures on which a sense of "lawfulness" are based.[36,37] External and internal order has turned into a sense of chaos, and the feeling of control over the universe or the self may have been obliterated as well. From this point on, the world may be perceived as arbitrary, a place in which it is impossible to predict events. In this author's view, this perception of ongoing chaos, helplessness and lack of control is essential for the diagnosis of a post-traumatic reaction, more so than any specific syndrome or behavior, even though this is not mentioned in the current symptom-oriented DSM.[36,37] Reconstruction of this sense of lawfulness, or learning to live without it, may be the most important goal of the treatment of reactions to trauma during the post-traumatic stage.

Furthermore, the sense of absence of control renders the individual helpless. The survivor may perceive the world as hostile, and him or herself as constantly under the threat of arbitrary entities. In order to forestall this sense of helplessness, the survivor may attempt to avoid stimuli that could trigger helplessness, which is imbedded in the traumatic memories. This avoidance, if it becomes a style of life, leads to a gradual contraction of life activities and to limited experience and social withdrawal. This self-limiting behavior is typical of post-trauma, and expansion of activities and experiences in order to recover the lost parts of life may be another important goal in the treatment of the post-traumatic stage. However, expansion of the repertoire of behaviors needs to be carried out in a measured and careful way so as to prevent emotional overloading that might delay recovery.

The post-traumatic reaction has an embedded conflict: on one hand, it relieves the traumatic experience, reduces dissociation, and expands life, but it also increases the sense of pain and helplessness. On the other hand, dissociation minimizes pain and diminishes helplessness, but inhibits the ability to cope with life and weakens creativity and communication. One of the solutions to this conflict is cognitive education about the traumatic process and its embedded conflict. Cognitive education may assist in the client acquiring new understanding of his/her situation, and may restore a sense of lawfulness and meaningfulness. This understanding also may promote the creation of new goals in life. The freshly acquired lawfulness encourages the survivor to be a more active partner in the healing process, rather than a passive recipient. It also contributes to the normalization of the healing process. Thus, treatment in the post-traumatic stage attempts to gradually reduce dissociation and encourage trauma reconstruction while avoiding emotional flooding through this process.

Another aim in the post-traumatic therapy is the acquisition of the ability to distinguish between feelings of helplessness stemming from external threats and feelings of helplessness, which emerge from within (i.e., re-living the traumatic experiences). The inability to make this distinction leads to a conviction of inner helplessness. With this ability, one is able to say to oneself "I feel helpless" or "I recall the experiences of helplessness", instead of "I am helpless". The ability to make such distinctions improves self-esteem and enables the initiation of diverse strategies of coping. This allows survivors to differentially respond: with alertness and overt action against an external threat, or with calmness and contemplation when the feelings are merely memories.[7,8]

Conclusion

This paper attempts to distinguish among the differences between crisis, stress, and traumatic stress. The essential difference is in understanding crisis in developmental terms—acute difficulty in the midst of the normal developmental process, while stress and traumatic stress deal with external threat and the ways of coping with it. Furthermore, crisis is brief, and has to be resolved promptly. In contrast, while immediate psychological first aid is needed for speedy coping in the stage of impact, the post-traumatic stage may linger for life.

These dissimilarities lead to critical differences between the treatments that are applied. While crisis is focused on growth by resolving the developmental issues, treatment of the traumatic process deals with minimizing helplessness and the perception of the collapse of lawfulness. Preventing

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the threat initially, and planning the coping strategies attain this.

This paper also delineates the difference among the three stages of the traumatic process, emphasizing the iatrogenic effect that may be caused if post-traumatic concepts are introduced in the stage of impact. Moreover, in this paper, the author warned against the prevailing tendency to pacify anxiety. Especially in the stages of alert and impact, anxiety is vital for promoting alertness and defensive planning. Its pacification may be iatrogenic as well.

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