Psychotherapy and Politics International
Psychotherapy and Politics International 12(2), 73–79. (2014)
Published online 13 October 2014 in Wiley Online Library
(wileyonlinelibrary.com) **DOI:** 10.1002/ppi.1330

Trauma under Fire: Treating Post-Traumatic Stress Disorder in Sderot

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ABSTRACT *This article provides an insight into the work of a child clinical psychologist in Sderot, a small city in the south of Israel that suffered for several years from rocket attacks from the adjacent Gaza Strip. The article discusses the intersection between clinical work and politics as it manifests in the diagnosis and treatment of post-traumatic stress disorder in the city. Using a clinical vignette, the article raises two questions regarding the responsibility of clinical psychologists. First, it invites them to consider political meanings during their clinical work, and second, to consider the role they play in creating a trauma-focused national narrative that preserves rather than tempers political conflicts. Copyright © 2014 John Wiley & Sons, Ltd.*

Key words: trauma; Israel; psychotherapy; politics

We heard the siren in the middle of a therapy session. A 13-year-old boy was in the midst of painting a large paper rocket in black gouache color. We had been co-creating it for several weeks. I heard his mother screaming outside. He looked at me, scared and confused, then grabbed the paper rocket and brought it with us as we ran with his mother to the shelter in the backyard of the clinic. We were all squeezed together in a small cement box waiting to hear the sound of the explosion, praying for the weak and distant sound of a rocket falling somewhere else. The child was hiding between his mother and me. I tried to say calming words and keep a confident facial expression. When the danger passed we were covered with stains of gouache colors that seemed like black wounds. The scared mother asked to end the session so she could take the child home where he would feel safer. We planned to meet again the following week.

In the winter of 2007, I arrived at Sderot to work as an intern in clinical psychology. Sderot, a small town close to the border with the Gaza Strip, became famous for being the target of constant rocket attacks from Gaza Strip since the beginning of the second Intifada. Civilian lives in the city were therefore governed by the frequent sirens warning of rocket attacks as the fighting between the Israeli and the Palestinian authorities escalated. In this article, I describe my experience as a child psychologist working with a population that was exposed to constant traumatic experiences. I try to place my clinical experience in the political context

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of the Israeli–Palestinian conflict and raise questions regarding the role of mental health workers in politically loaded situations in which the diagnosis and treatment of post-traumatic stress disorder (PTSD) are of political consequence.

BACKGROUND AND INITIAL OBSERVATIONS

By 2007, seven years after the first rocket attack, many of the residents of Sderot had left town. As a result, the town felt deserted and forgotten. The old housing projects were sunburnt and rusty, and most backyards were full of blackthorn and dry weeds. Ironically, throughout the town, the streets were decorated with colorful banners with greetings that included: “Citizens of Sderot, the nation supports you”, “Be strong and courageous”, and “Zionism will prevail”.

The child clinic where I worked consisted of two therapy rooms at the rear part of the mental health building, both unprotected from rockets (the cement room I described previously was built in the clinic yard only few months later). During my orientation I was instructed that if I heard siren sounds I was to stand in the hallway with my patients until I heard the rocket falling elsewhere. Anxiety characterized this peculiar time and place; cries of despair and the terrified screams of patients would follow each siren. Some, usually older patients, knew better than the staff that there was no safe place to escape to. They also knew that, considering their violent surroundings, even the best treatment could not help reduce their anxiety.

Every afternoon as I drove home to Tel Aviv, I forced myself to forget those hours of fear. But at home, despite the geographical distance from immediate danger, my anxiety was obvious; my heart would skip a beat each time an ambulance drove by my house. On national television, Sderot was often the main news item; citizens were interviewed crying with anger and despair as they described the horror of a rocket falling on their homes. Politicians would also be interviewed, pointing west towards the Gaza Strip and blaming the Palestinians for the suffering of the people of Sderot. They would frequently claim that only a large military action, retribution with devastating consequences for the Gazans, could save the people of Sderot.

During the violent periods, when the number of rockets falling each day peaked, citizens evacuated themselves to safer places with the help of private donors. Soldiers filled the streets of the town while the Israeli Air Force bombed Gaza, turning whole neighborhoods into dust, citizens into refugees, and cultivated fields into ashes. When the bombers returned to their bases and the town became quiet, the citizens of Sderot would return to their houses, and attempt to enjoy the short break in their war routine – before the rocket launchers in Gaza resumed their attacks.

THE DILEMMA OF THE CHILD PSYCHOLOGIST

As a mental health provider I was not supposed to ask the citizens what they thought was the price of the temporal quiet they were enjoying. Questions regarding the impact of the military actions on the citizens of Gaza seemed unrelated to my clinical work, politically charged, and inappropriate. The only appropriate question was whether the military action was strong enough to procure a longer period of tranquility. In a way, the military attacks held the

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promise of a temporary relief to the town, distracting the people from their suffering and helping them feel acknowledged and cared for by the government and the Israeli public. But shortly after the military attacks ended, promises made during the war of financial investments, shelters, and better psychological services remained unfulfilled, leaving the town as poor as before and as unprepared for the next violent cycle soon to come. I noticed that when the rockets from Gaza were not falling, Sderot's cries for help were rarely heard. It was only in 2008, following a lawsuit filed by Sderot citizens, that the Israeli government was forced to take full responsibility for shielding the city.

I saw a large number of children during my work in Sderot. I saw their fear, their helplessness, and their despair. I witnessed the extent to which these children suffered and the negative impact of the constant stress on their everyday lives and development (the high prevalence of stress reactions among adolescents in Sderot is also described in Berger, Gelkopf & Heineberg, 2012). I appreciated the opportunity to work with these children, to provide ways to relieve the anxiety, and to listen to their stories. Nevertheless, as time went by, I began questioning the meaning of the help I was providing and the long-term consequences of it.

The 13-year-old boy I began this article with arrived at the clinic suffering from severe anxiety. For a long while he had refused to leave his house. His mother stayed home with him all day, too worried about him to leave him alone. He agreed to come to therapy or to meet with friends only when accompanied by her. The traumatic experience of being under rocket fire, more than his school or social difficulties, filled most of our sessions. Each time we would draw together, he drew a rocket; every time we would sculpt, he sculpted a rocket; and when he told stories, they were about rockets. His fear of rockets seemed to penetrate most aspects of his life, leaving little room for other themes or interests to develop.

One day he told me about a dream in which he heard a siren and then the horrible whistle of the rocket flying over his house. In the dream, he overcomes his fear by climbing on to the roof of the house and jumping on the rocket. While sitting on it, he manages to change its direction and turn the rocket back to Gaza. The rocket he was riding exploded on Gaza, demolishing the whole city and killing all its citizens. At the end of the dream he was declared a national hero, receiving love and admiration from all the people of Israel and Sderot.

What should I have told him about his dream, I wondered. I could not help thinking about children his age in Gaza. Concurrently, I wanted so much to offer supporting words that might help him feel strong and effective amongst the chaotic reality into which he was born. In the psychotherapy training I received for dealing with PTSD I learned to debrief, to encourage expressive talk about the trauma, to listen empathically, and to convey to my client that he was not alone. But in that moment of listening to the child's enthusiastic description of the demolition of the other side I could not avoid thinking that in Gaza, in a similar therapy room, another therapist was listening patiently to a child telling her about his dream of demolishing the town of Sderot.

What would the Palestinian therapist choose to tell that child? Would she support his fantasy? Would she tell him about the children in Sderot who hide in shelters? Nothing in the role of trauma therapist suggests any responsibility for addressing the political aspects of the experience of the traumatized children I met. No one seemed to think that psychologists have any role in this vicious cycle of bombing and trauma and bombing again, besides listening empathically to the misery and to the gradually developing feelings of hate and desire for revenge.

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As time went by, I felt more and more helpless and angry, much like the citizens of the town. Like them, I felt I was sent to play the role of a national icon representing strong devotion and will, although my actual work in the city could not offer any meaningful help. I was hired to soothe my patients; to help reduce their anxieties. But my work, as I learned with time, was not about improving the life of my patients or bringing an end to their constant misery and fear. My work was to help the suffering children better adjust to their impossible situation so they could maintain their lives between the rocket attacks and stay in the town despite their terror. With my soft words and understanding comments I was encouraging them to stay where they were (Summerfield, 1999) – but what for, I asked myself? Why were mental health providers needed, paid, and risked if they were able to offer little or no change?

DISCUSSION

In their book *The Empire of Trauma* Fassin and Rechtman (2009) challenged the "reality" of the post-trauma diagnosis and talked about the creation and utilization of "trauma" to eliminate personal and political meanings from emotional reactions to disasters. According to them, the use of trauma has become so prevalent that no one dares to suggest there could be different reactions, or even no emotional reactions, following a disaster or horrifying national event.

In Sderot, the diagnosis of PTSD allowed for the immediate recognition of suffering by the authorities and the media. Other emotional difficulties such as family conflicts, social anxiety or behavioral disorders that could not be linked directly to the rocket attacks would often remain unattended to or postponed until a different, more peaceful time since no resources were available for needs that required long-term investments. The citizens I met therefore learned to use the language of trauma as the only meaningful way to communicate their difficulties and distress.

Fassin and Rechtman (2009) further argued that psychotherapy interventions such as debriefing or retelling the story of traumatic events help to shift the personal experience to the public sphere. In the debriefing process the diverse emotional reactions are clustered by the PTSD definition into one narrative and linked to a single cause that has public or national meaning. The mental health worker sent to treat post-traumatic reactions defines for the client his symptoms as meaningful and related to the external public event. When the emotional suffering is filtered through the pressure to externalize, the personal sources of the trauma, as well as political implications, are left outside the therapy room, defeated by the power of the national event. Through encouraging the expression and consolidation of the trauma narrative, mental health professionals are complicit in manufacturing emotional suffering into a living testimony of disaster and an unmistakable representation of it. This representation is often broadcast in the national media, impacting on the way the society views and experiences the event.

In a fascinating article about the Tamil Militias in Sri Lanka, Ramanathapillai (2006) described the way in which collective memories of trauma helped to consolidate the Tamil identity and their fight against oppression. But the telling of traumatic experience had an additional meaning: it was used to create a strong and undisputable sense of victimhood amongst Tamil society, and was later used to justify the militias' brutality and dehumanization of the other side. Ramanathapillai suggested that the personal and intimate

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qualities characterizing a trauma story tend to elicit an emotional reaction in the listener, a reaction that easily develops into feelings of anger and the desire for revenge.

According to Ramanathapillai (2006), the testimony of the trauma victims carries the significance of a national truth. With its clear narrative of horrifying events and victimhood, it encourages a single or one-dimensional perspective of reality. The trauma-based perspective, in a way, encourages group conformity and intensifies the hostility and anger towards external groups. As Ramanathapillai wrote: "The more party leaders used stories of the painful past in their political campaigns, the more the Tamil youth became agitated and radicalized" (p. 6).

In another example, taken from the work of a mental health professional in Gaza and the Left Bank, Fassin and Rechtman (2009) described the experience of mental health workers who visited Palestinian citizens following an Israeli military attack. The mental health professionals, by listening to the descriptions of trauma, were used as "objective" witnesses who could later testify about the horribleness and cruelty of the Israeli attack:

> The aim of humanitarians is, through symptoms and affects, to attain to the incontrovertible truth of their patients' condition, one that could not be challenged because it is based on testimony that is by definition impossible to refute or to reinterpret for political or partisan ends. (Fassin & Rechtman, 2009, p. 211)

The memories of those who were defined as traumatized were collected by mental health providers and later used as chronicles to describe the suffering of the Palestinian people. Since the memories were collected after disastrous events and focused on the description of their aftermath, other parts of the people's personal experiences or other meanings and explanations (for example, issues involving gender or sexual oppression, religious and class conflicts) were erased from the narrative. On the Palestinian side, the traumatized people became the map through which actual events were read.

In Sderot it was difficult not to identify with the anger and pain of my patients and their parents. But, with time, I learned that seeing the situation only through the scared child, the angry mother and the revenge-seeking father did not enable me to better understand the reality of the town, and the reason things had kept getting worse as the years passed. I felt that I was invited to empathize, feel the anger, and experience the pain, but was not expected to go beyond it as a psychologist and discuss openly other things I had seen in the town: the poverty, the decline of community solidarity, and the anger towards the authorities for their neglect. As an aside, Gelkopf, Berger, Bleich, and Cohen Silver (2012) compared the level of reported traumatic symptoms of the citizens of Sderot to citizens of Kibbutzim and Moshavim who suffered similar rocket attacks. They found that Sderot's citizens reported significantly higher rates of emotional distress and post-traumatic symptoms than their neighbors. The authors suggested that factors such as economic stability, social solidarity, authority support, and confidence in authorities served as protective functions, helping to mitigate stress-related reactions in the rural communities.

It was also difficult for me to celebrate with my patients their ability to maintain normal life most of the time. There was no room in the clinic's meetings, in supervision, or in therapy to raise complex questions about the situation. Who profits from keeping the situation the way it is? Which long-term solutions could be promoted by the citizens? Is it possible to create a different account of their suffering that would also include the Palestinian citizens?

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These questions, as well as other clinical formulations of the experiences, were not welcomed in Sderot. According to Avissar (2007), since the outbreak of the second Palestinian Intifada in 2000, questions that challenged the national narrative of victimhood were not welcomed in Israel. It was, therefore, difficult to suggest alternative interpretations to a family. For example, I could not tell the family of the 13-year-old boy that his rocket anxiety may be protecting his parents' shaky relationship or helping his mother feel competent and active and thus conceal her underlying depression.

The citizens of Sderot seemed like valuable political cards; too politically valued to be given a voice of their own to express emotions other than anger and fear, and too important to be given an opportunity to ask for more than simple revenge. As a mental health provider in a small, unprotected clinic with limited resources, we were providing emotional or pharmacological first aid following the rocket attacks, but it was difficult to maintain long-term therapy as that would require convincing patients and their parents that therapy was worth the risk of leaving the relative safety of home. The post-trauma diagnosis and the debriefing interventions were almost the only help seen as valuable for the citizens. Without intending to, I became a trauma-oriented provider, encouraging the citizens through brief interventions to define their experience in relation to trauma, to focus on the particular traumatic event and to re-experience it as central to their current emotional situation.

The trauma focus turned me into a live "objective" witness of the vicissitudes of the rocket attacks. Much like the Palestinian mental health workers described in Fassin and Rechtman (2009), my presence assisted in translating personal experience into terms that were meaningful for the national public, giving it a public meaning of continuous national victimhood.

In his article about the importance of politically informed psychology in Israel, Avissar warned that:

> Without an ethical compass, at times of conflict and distress mental health practitioners (in both private and organizational settings) are thrown into the turmoil and react just like the rest of the public: with panic and helplessness, blindness and stagnation. Without an independent perspective, psychologists will not be able to make a valuable and unique contribution to the social and political life of their community. Without such a perspective, real change may become virtually impossible and psychotherapy will at best allow for an adjusting process to the harsh political reality (alternatively and more frequently, total avoidance or denial of the political characterizes psychotherapeutic work). Through this process, psychologists take part in perpetuating the status quo and sometimes become accomplices to the production of suffering. (Avissar, 2007, p. 6)

CONCLUSION

I asked to terminate my work at the clinic six months after I started it. When I left Sderot, I thought that, despite my goodwill and empathy for the citizens, the way to stop their misery was not through therapy. Since their misery seemed to serve so many political aims, it occurred to me that listening to it would not produce any meaningful and long-term help. It would not help change the vicious cycle Sderot had been locked in for years. Instead, I felt that through my presence I reinforced the citizens' role as victims of the conflict, lacking agency and control.

Only after quitting my job and leaving the town did I begin to wonder whether it was possible, in the small unshielded room, to listen to my young patient's dream and invite

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him to further explore and develop it. For example, might he imagine different scenarios or possibilities to end the dream, like one in which he could steer the rocket to an empty field outside the town and make it explode there, where no one could get hurt and the scared child in Gaza would be safe as well? How would he experience me raising alternative options? Could a clinical reaction that considers the political context and encourages reconciliation offer him more hope in the long term? Looking back, I know I was too anxious and insecure in my role to do that. Like my clients, I needed to feel physically safe and emotionally supported before I was able to explore any alternative ways.

ACKNOWLEDGEMENTS

Thanks to Lawrence Zelnick PsyD, my clinical supervisor at Long Island University, Brooklyn, for his support in the process of writing this paper, and for his thoughtful comments and suggestions.

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