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Family crisis intervention in war contexts: a case study of a traumatised Palestinian family

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The aim of this study was to analyse the phases of an innovative in vivo exposure intervention in which all family members were present at the scene of a traumatic incident. Clinical practice has borne out the efficacy of family intervention and its benefits for traumatised individuals and family groups. The intervention discussed here was conducted with a Palestinian family that had suffered trauma in a missile attack during the Israeli–Lebanese war of summer 2006. Narrative and meaning-reconstruction methods were combined with cognitive-behavioural techniques. The study highlights the limitations of the intervention as well as suggesting future directions for integrated models of crisis intervention; development of an evidence-based model is recommended.

Keywords: early intervention; war context; family therapy; post-traumatic stress

Introduction

This study is a part of a broader line of enquiry that seeks out and tests new models of clinical intervention for war-traumatised populations. Studies within this tradition draw on a range of theoretical models to develop techniques for rapid and effective intervention in extreme situations, such as natural disasters, terrorist attacks, etc. (De Jong & Kleber, 2003; Katz, Pellegrino, Pandia, Ng, & De Lisi, 2002). The largest amount of empirical evidence collected to date concerns standard cognitive, and cognitive behavioural, therapies which have been found effective mainly in reducing symptoms, modifying irrational beliefs linked to the traumatic event and stopping rumination and catastrophic thinking (Miller, Kulkarni, & Kushner, 2006). A second important line of research has examined therapies using narrative techniques and the reconstruction of meanings associated with trauma, bereavement and loss (Miller et al., 2006; Nelson Goff et al., 2006). A large number of studies report the efficacy of narrative and family therapies in treating complex and cumulative trauma (Devilly, Gist, & Cotton, 2006; Jordan, 2006). A third strand of research has assessed integrated models combining direct interventions in the context of the trauma with behavioural techniques aimed at resolving post-traumatic stress at the intra-individual level (Bousquet Des Groseillers, Marchand, & Brunet, 2006; Kazak et al., 2006). Such integrated therapies most frequently involve multi-level intervention that takes into account the principal biopsychosocial aspects involved in the complex traumatic constellation (Lloyd et al., 2005).

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Renewed interest in constructivist paradigms, social-constructionist and narrative approaches in the assistance and care of refugees, asylum seekers and war victims has contributed to a radical revision of traditional medical and psychiatric models for the treatment of extreme and cumulative trauma, and a critical revision of post-traumatic stress disorder (PTSD; Durst, 2000; Norman, 2000; Pumariega, Rothe, & Pumariega, 2005; Young, 1995). Young (1995) stressed that the diagnostic category of PTSD is closely related to a specific geographical background and time and as such unavoidably undermines the cultural, socioeconomic and political variables characterising other ethnic groups and geographical areas. In other terms, the voices of war victims have been trapped in a universalistic psychiatric category requiring standard intervention in line with Western biomedical models (Turner, 1992).

One of the most evident consequences of cumulative and extreme trauma is the progressive loss of meaning: the emotional and cognitive premises orienting the individual are disrupted by trauma, forcing the traumatised person into a fragmented, unpredictable and incoherent system of meanings. Post-modern and social-constructionist models postulate that identities develop within inter-subjective experience, hence systems of meaning comprehend interrelated and coherent micro- and macro-individual, familial and collective narratives. The information received by individuals from the context, that is to say from their relational networks, helps them to build coherent meaning systems; vice versa each individual contributes to the co-creation of interactional contexts (Crossley, 2000). Contexts thus generate meanings that either reinforce or mitigate the suffering experienced as a consequence of loss, bereavement and trauma. Assuming that culture exerts a strong influence over emotional experience at a deep level, traumatic events may be seen as having an impact at a deep level and as being processed mainly collectively. In this sense, individual responses may reflect 'a political ethos that characterizes a whole society' (Jenkins, 1996, p. 177). Summerfield (1996) observed that the most severe post-war psychological sequelae and forms of complicated grief are largely determined by the social context. An alternative definition to classical PTSD is that proposed by Baker (1998) of 'extreme trauma'. This definition of trauma allows a distinction to be made between the psychological suffering caused by war and political violence and that produced by other kinds of disaster. When we speak of extreme trauma, we refer to an individual and collective process related to a specific social context. The main variables in this process are the intensity, lifetime and interdependence of psychological and social dimensions. The process disrupts natural ability, both individual and collective, to deal with adversity, fragmenting individuals' subjective sense of belonging to society. Extreme traumatisation is not subject to any temporal limitation and develops sequentially.

Increased sensitivity to cultural factors and the critique of the classical PTSD diagnosis have contributed to the development of integrated approaches to trauma intervention. Such approaches allow for ethnographic and cultural variables, making the intervention more adaptable to the specific case (Voulgaridou, Papadopoulos, & Tomaras, 2006). Furthermore, the support provided to traumatised people may be reinforced by the introduction of non-clinical elements, such as social support and community-oriented intervention (Van der Haar, Heijmans, & Hilhorst, 2013).

The emerging paradigms of trauma intervention in war-affected zones increasingly include different bio-psycho-social levels so as cater more adequately for heterogeneous populations of war refugees and asylum seekers.

A non-pathologising perspective on trauma looks at the natural resources of individuals recovering from adversity and stress, designing intervention within an 'ease'-oriented framework rather than from a 'disease'-informed perspective.

Furthermore, numerous studies report a sense of growth in individuals in the aftermath of trauma (Joseph & Linley, 2006). These works show self-reflective activities and subsequent meaning-making to be essential to achieving growth. Tedeschi and Colhoun (2004) introduced a new perspective on trauma recovery through the construct of post-traumatic growth (PTG). PTG is displayed by individuals who despite having faced major challenges in their lives, maintain a strong ability to 'to balance reflection and action, weigh the known and the unknowns of life, be better able to accept some of the paradoxes of life, and to more openly and satisfactorily address the fundamental questions of human existence' (Calhoun & Tedeschi, 1999, p. 21). The authors refer to a complex phenomenon not reducible to a coping mechanism, cognitive distortion, psychological adjustment, well-being or a host of apparently similar constructs. The features of the PTG process must be considered iterative. This process is likely to involve a combination of demand for emotional and cognitive strength that is achieved through construction of a sense of coherence, with a higher-order script that allows for the appreciation of paradox and uncertainty (Tedeschi & Calhoun, 2004; Veronese, Fiore, Castiglioni, el Kawaja, & Said, 2013).

In our preliminary analysis of the single case study presented here, we introduce an innovative crisis intervention model that combines the reconstruction of narratives – fragmented and caught in the vice-grip of trauma – with the prevention and/or treatment of post-traumatic responses in war victims. We discuss critical aspects regarding the implementation of the intervention in the field as well as the need to develop an evidence-based model for this type of crisis intervention.

Cognitive behavioral (CBT) interventions in war-affected areas

The CBT technique aimed at preventing and/or defusing the mid- and long-term effects of trauma is known as psychological debriefing. It is a short-term intervention implemented two or three days after the disaster, and comprises practices such as ventilation, catharsis, normalisation of stress factors and psychoeducation about symptomatic reactions. Variants include critical incident stress debriefing, group reconstruction of the traumatic incident and critical incident stress management which add some elements of self-help (Everly & Mitchell, 1997). Abundant empirical evidence has proven the effectiveness of CBT in war-affected areas. However, doubt remains about both individual differences with regard to trauma exposure and normalisation in terms of improvement in symptoms and social disadaptation (Gist & Devilly, 2002). Prolonged exposure is in vivo exposure (8–11 sessions) aimed at promoting cognitive restructuring and techniques of anxiety management in the aftermath of trauma (p. 24, 25). Outcome studies have reported good remission of PTSD symptoms and trauma-correlated depression (p. 71).

The most evident limitation of CBT is the total absence of procedures that are culturally sensitive and oriented to the social context, thus undermining one of the key domains influencing the mental health of war-affected individuals: the social sphere (p. 9).

Narrative approaches and family therapy in war contexts

Narrative approaches have also been found effective in contexts of extreme trauma, violence and war (Denborough, 2008; Veronese, Castiglioni, & Said, 2010) and bereavement

(Neimeyer, 2006; Stanworth, 2004). Studies report that the psychological impact of war trauma may affect the whole family, even when only one member has been directly exposed to stressful events (Kiser & Black, 2005). Furthermore, immediate and long-term responses to trauma can either reinforce or mitigate the dysfunctional reactions of one or more members of a family affected by trauma. Strategies of prevention and care for war-affected populations should, therefore, take into account the socio-ecological dimensions of suffering, and specifically target family transactions and processes. In line with strong empirical evidence on the impact of trauma at the family level (Zerach, Solomon, Horesh, & Ein-Dor, 2013), intervention with family systems is aimed at regulating the stress of individuals within their family context. Furthermore, we need to fully consider the family's system of beliefs and narratives in light of its culture and community (Papadopoulos, 2002). Narrative interventions allow traumatised individuals to integrate traumatic suffering into a narrative script that is embedded in their micro- and macro-cultures. The aim of narrative intervention is to reconnect individuals with the personal and collective resources required to deal with war-related losses (Denborough, 2008; Meichenbaum, 2006). Religious, traditional, cultural, political and economic domains all play a part in narrative intervention, reinforcing protective factors that empower individuals affected by war and violence (Denborough, 2006). In line with our earlier comments on the PTSD model, narrative approaches may be viewed as strongly critiquing traditional perspectives on PTSD (Batniji, Van Ommeren, & Saraceno, 2006; Miller et al., 2006). Narrative intervention does not rely on standard procedures and protocols, but emphasises the collective narratives that survivors produce as a form of witnessing. Witnessing is a means of enhancing individual and collective resilience. The counsellor eliciting the victims' narratives tries to identify positive factors that can endow events with sense and coherence (Crossley, 2000).

Case study

The intervention context

We now outline our case study of a therapeutic meaning-reconstruction intervention conducted with an individual family during a period of armed conflict. The family in question – an Arab family resident in Galilee, a region in the north of Israel – had suffered severe trauma as a result of a missile attack during the Israeli–Lebanese conflict of summer 2006. The marked inequality with the Jewish population not only increased the feeling of marginalisation and isolation on the part of the Arabs, but also instilled in them a sense of fear and abandonment without precedent: as Palestinian 'blue card' (Israeli passport) holders turned war victims, they were now truly foreigners in their own home (Veronese, Castiglioni, & Said, 2011). The Arab helps professionals implementing the intervention protocol moved around the conflict zone with foreign volunteer workers including one of the authors of this study, offering their assistance on a totally voluntary and unremunerated basis.

The phases of the intervention

The intervention proposed to the victims consisted of four phases plus a preliminary stage involving the *mapping out of the territory affected by the* disaster in order to identify intervention priorities in terms of urgency and danger. Average duration of the on-the-ground intervention (Phase 1/Phase 4) was 2 hours, with a range from 1 hour and 30 minutes to 2 hours and 30 minutes.

During the preliminary stage, the social services (or other local agencies specialising in crisis response such as non governmental organisations or community psychological services) established initial contact with the traumatised families. On the basis of the information gathered by the social workers, an initial assessment of the population affected by the disaster was carried out by the team of emergency workers who then contacted the affected families in descending order of gravity with a view to arranging a meeting with them within a very short lapse of time (from 24 hours to one week after the missile attack).

Phase 1 was the beginning of the in loco intervention proper (field intervention). A counsellor met the traumatised family, having requested the attendance of all the immediate family and of any other relatives or other significant figures that had been present at the critical event. The first part of the meeting was designed to promote *joining* and familiarisation between the counsellor and the family. After a short presentation of the intervention during which each phase of the intervention was outlined to the family members, the counsellor enquired about the principal changes that had taken place in the family as a result of the disaster (Phase 1a), that is to say, the everyday running of the family before and after the crisis. The symptoms of each family member were then recorded via a clinical-diagnostic interview (Phase 1b; Gabbard, 1995).

The second phase (Phase 2) consisted of two psychoeducational sessions designed to increase the family's level of knowledge and awareness of how they might be affected by the traumatic event and how they were going to work on this with the counsellor (preparation/alliance).

In the first step (Phase 2a), the main physiological and psychological responses to trauma were described to family members using a language appropriate to their sociocultural background. The counsellor drew on two theoretical frameworks, a neuropsychological model (Ledoux, 1986) and a psychological model based on the psychological mechanism of avoidance-exposure (Marks, Lovell, & Noshirvani, 1998). The primary aim of this step was to prepare the family for the repetition of the traumatic scene by explaining physiological reactions to traumatic events, and to increase their level of awareness and recognition of their individual reactions during the critical event itself and during the exposure. A secondary objective was to promote unity amongst family members by raising their levels of attention, motivation and emotion regulation before undergoing the intervention proper. During this step, metaphors and stories, such as the comparison with animals under attack and their 'fight, freeze and flight' reactions, were applied to the family's narratives which tended to be dominated by the traumatic event, in order to introduce system perturbations. The second step in this phase (Phase 2b) consisted of drawing up the working contract. At this stage, informed consent was signed by each member of the family. The individuals were informed of the potential benefits (in terms of recovery from symptoms, enhanced awareness and family cohesion) and risks associated with re-experiencing the trauma. Each member could withdraw at any time if unable to continue. The counsellor undertook to respect the choices of each family member as well as the well-being of the family throughout the programme. In preparation for the following in vivo exposure phase (Phase 3), the counsellor communicated to the family, a set of rules to be respected by all parties. For example, all family members were requested to attend and take active part in the session, to respect the behavioural and emotional reactions of the other members and to avoid intruding on the other members. The third phase (Phase 3), the in vivo exposure intervention per se, consisted of the detailed re-enactment of the actions of each family member at the exact time of the disaster. First, the family group and the counsellor accompanied individual family members as each in turn went back over the ground covered from the moment in which the missile had struck

(Phase 3a). Two guideline criteria were used to determine the order in which the family members were asked to go back over the scene of the disaster. The first criterion was the level of emotional activation displayed by the various family members: typically the counsellor chose the member with the highest level of emotional activation and/or the most strongly motivated to begin the session. None of the participants were forced to go back over the scene. The second criterion came into play when some of the family members were children, in which case the counsellor tended to choose one of the parents to go first, typically the parent who seemed better prepared to relive the traumatic event. This strategy allowed the children to feel that they could legitimately express emotions that could have been discouraged or criticised by the less prepared parent, who often found the process difficult and was less open to interacting with the counsellor.

The whole family shadowed the movements of the member that was about to relive the traumatic scene, observing the exact position occupied by that person immediately before the event took place. Trauma causes a rupture in the victims' identity continuum, at the emotional, cognitive and behavioural levels (Tjersland, Mossige, Gulbrandsen, Jensen, & Reichelt, 2006). Going back over the moments immediately prior to the disaster allows traumatised individuals to reconnect with their previous life context and to identify the hurt inflicted by the trauma, facilitating a first reconstruction of meaning in the direction of a new and more functional perceptive and emotional structure (Jenkins, 1996; Norman, 2000). The creation of a space for dialogue between counsellor and traumatised family, among family members and, finally, among the interiorised voices of the member that is reliving the scene, helps that member to gradually enrich his/her narrative with new meanings, through the externalisation of emotions and thoughts that up to then had seemed impossible to express. All the family was invited to repeat and analyse the behaviour patterns displayed by the individual member at the time of the disaster. During this phase the counsellor adopted a strongly interventionist and directive approach aimed at correcting irrational ideas and catastrophic thoughts on the part of the patient that were forcing him/her into a fragmented and disorganised partial reedition of the trauma (Heckman, Cropsey, & Olds-Davis, 2007). As individual members progressively enriched their repertoire of cognitive and emotional meanings, the whole family was helped to reinterpret the critical event from alternative viewpoints. Positive feedback from the family, encouraged by the counsellor, also helped individual members to engage their own emotional resources and coping strategies in the difficult process of exposure to the trauma. Attempts to criticise or attack the member reliving the scene were immediately blocked by the counsellor through the provision of positive reinforcement and meanings. The third phase proceeded with a debriefing (Phase 3b) by the counsellor that highlighted the courage and restored unity of the family. Attributing value to the competence and resources of the family helps to reinforce behaviours based on closeness, solidarity and mutual support. When the most traumatised family members were children, it was of particular value during this step to visit places, people or surroundings towards which the victims were displaying avoidance. This strategy helped to reduce fear and overestimation of the probability that the event could recur in the same location. A secondary objective was to help the victims reconnect with their community, given that they had isolated themselves in the aftermath of the trauma, restricting their physical and psychological perceptive fields. The final step in this phase (Phase 3c) consisted of providing practical advice about how to behave and how to minimise harm if the event should recur. The aim here was to further enhance the family's sense of self-efficacy and ability to regulate one another's emotions.

If after the re-enactments and debriefing, one or more members of the family affected by the disaster clearly displayed a higher level of emotional and psychophysiological activation than the family average, along with a degree of suffering that was a cause for concern, individual therapy was recommended. Individual treatment methods were chosen ad hoc to suit the specific needs of patients with evident signs of cumulative and extreme trauma.

The fourth and last stage consisted of in loco follow-up at two/three weeks (Phase 4a) and three months (Phase 4b) from the intervention. The aim after two/three weeks was to monitor the efficacy of the intervention and the short-term changes, and after three months to monitor whether the effects of the intervention had been maintained.

By way of example, a single case is outlined in the following to illustrate the main – specific and aspecific – process variables characterising the interventions.

The case of the Esmail family

Preliminary phase – mapping the territory

Following a Lebanese *Hetzbollah* missile attack against Israel, a *Katiusha* missile struck a densely populated street in the Arab suburb *Kaukab Al Shamal* northwest of Nazareth. The attack killed 2 children, aged 4 and 7, and wounded some 30 people. When the missile struck, the Esmail family was close to their home.

The family unit was made up of four people: Najwa (aged 65), an insulin-dependent housewife who also suffered from low blood pressure and rheumatism. Jamal (aged 30) a building worker who lived with his mother and was not married; Ziad (aged 28) who worked in a plastics factory and had a serious stammer, exacerbated by the missile attack; Nadia (aged 36), who had been married for 13 years, without children. She had had one miscarriage and had also lost a 35-day-old baby. Najwa's husband had died 27 years previously, when Ziad was about 1 year old. The Esmail family is part of the group of internal refugees who fled to Nazareth in 1948 from Endur, a village east of the town of Afula, in southern Galilee, after their land was expropriated by the Israeli Government. Najwa was just 10 years old at the time.

When the attack came, a 20-year-old cousin, Omar, currently unemployed, was also in the house. Following the explosion, the whole family rushed to the site of the disaster, fearing for the lives of their loved ones. They were confronted with a scene of death and despair. The bodies of two children lay lifeless on the ground, while numerous wounded victims were screaming and crying in terror.

Phase 1 – field intervention

Since the missile attack, numerous changes had occurred in the family: all members appeared extremely stressed and hypervigilant; they were almost all suffering from somatisation, difficulty sleeping, nightmares and symptoms of depression. The two brothers involved in the disaster appeared to be on bad terms with each other. Their mother, hitherto the most authoritative figure and undisputed leader of the family, could not persuade her children to get on.

Mrs Najwa was a plump woman who looked older than her 65 years; she had suffered a few episodes of incontinence. She had difficulty getting to sleep, was suffering from nightmares and, especially, she was obsessed by a recurring dream about the disaster. Several times a day, Najwa suffered from auditory hallucinations, she could hear the missile exploding and this had a terrifying effect on her. She was also tormented all day

long by intrusive and catastrophic – 'we could all die from one moment to the next' – memories of the event.

Jamal since the day of the explosion had been suffering from bad headaches, muscle pains in his back and partial deafness. He was finding it difficult to sleep, waking up several times a night with terrible nightmares and dreaming that he was being blown up by a missile or being knocked down by a huge explosion. He had various psychological symptoms such as flashbacks about the victims; like his mother, he sometimes heard the blast of the explosion and was obsessed by intrusive thoughts such as never being able to come to terms with the death of the child – 'how can you possibly accept the death of such a beautiful little child?'. Jamal's moods were dysphoric: they swung between moments of rage and irritability – especially towards his brothers and sisters – and moments of depressive withdrawal, during which he isolated himself from others, smoking excessively.

Ziad was a small-boned, fair-skinned young man who seemed to be the most fragile of the family, both physically and psychologically. He was suffering from tremors and bouts of vomiting, muscle weakness and pains in his joints. Ziad's main psychological symptoms were flashbacks about one of the victims of the explosion, a child whose face was devastated by the bomb. He was terrified of leaving his home. Ziad seemed hyperactive; the slightest noise threw him into a state of alarm; and he had difficulty concentrating, especially when he had to follow what other people were saying. He had suffered from a stammer since he was about 11 years old. Since the disaster, this stammer had worsened: at times it was almost impossible to understand what he was saying. As he spoke, Ziad's face was contorted by uncontrolled grimaces and tics.

Nadia was a plump woman with an expression of constant fear: fear of such an event happening again. Her main physical signs of the trauma were: an increase in her normally high blood pressure, bad migraines and sudden pains in the joints of her legs. Her most obvious psychological symptoms were the panic attacks that first started when the disaster happened and now occurred every time she heard loud or sudden noises.

Omar was a slight youth who lived about 1 km from the site of the disaster, but had been at his aunt's house when the missile struck. He suffered from panic attacks triggered by unexpected sounds and noises (especially the siren warning of an imminent missile attack).

Phase 2 and Phase 3, preparation/alliance and in vivo exposure

The family seemed to acknowledge that Jamal was the person most exposed to the event. They all looked frightened and agitated. Jamal's mother was short of breath as she kept close to her son throughout the re-enactment. Terrorised, Nadia repeatedly closed her eyes, constantly at the beginning of the walk, later only at the most dramatic moments. Ziad stayed to one side, his face red and his expression void and lifeless. Omar observed Jamal attentively and seemed to be very close to him. Jamal had come home from work at around 4.30 pm when he heard a deafening blast. He rushed out into the street and was confronted with the sight of the lifeless bodies of two children on the ground. He approached one of them, knelt down and took the child's body in his arms. While holding the body in his arms, Jamal realised that the child was still breathing very faintly, his chest moving almost imperceptibly:

C: What is crossing your mind in this moment, Jamal?

J: Only one thing, only one damned thing;

C: what are you thinking of, Jamal!?

J: I'm thinking that there is someone from my family amongst the victims, I'm looking for them in the dust.

C: I can feel your suffering Jamal, I can feel your emotions, the effort you are making!

J: I'm desperate. desperate, desperate – that child is still alive, he wants to carry on living…

C: you are holding him close…

J: he is all swollen, deformed…by the attack, I'm holding him in my arms… (He cries in despair).

Ziad was the second person to cover the route taken at the time of the disaster. His language was fragmented, his movements slow and stereotyped. He immediately defined himself as a weak – 'sensitive' – person, as if he wanted to ask the counsellor to prevent him from having to relive such suffering. The re-enactment with the counsellor was the first occasion on which Ziad had stepped outside the house since the disaster. At the end of the route Ziad looked shocked, there did not seem to have been improvements in terms of his physiological and psychological activation. At the end of Ziad's route, the counsellor made an about-turn and decided to give Ziad and his family an in vivo restitution:

C: Focus your mind Ziad, concentrate and tell me at what other moment in your life you have experienced these same emotions?.

Z: …mm…no, I.I can't remember… no…

C: already.this already happened… take all the time you need…

Z: a few years ago… maybe… a few years ago….

C: a few years ago… already!… a few years ago…

Z: three years ago Mummy fell. She was seriously ill, she was about to die, and I with her…

Ziad, who initially seemed unable to identify specific events, suddenly recalled how three years earlier he had witnessed his mother falling and for a moment had been afraid of losing her. Since then, his fear that she might die or that something might happen to her had continued to condition his life. The youth said that he often slept next to his mother and never took his eyes off her:

C: Najwa and Ziad, please sit facing each other… like this… one in front of the other.

Today's fear is the same as it was then, now just like then. Tell Mummy that, Ziad.

Z: …I was frightened I was going to lose you… lose… for ever (sobbing)

C: Have you had to look after your mother Ziad, since then?… always…

Z: …I couldn't help her… I couldn't help her.

C: It's important for Ziad to tell Najwa how much he loves her – hug her Ziad!

The emotive atmosphere of the session changed and, momentarily, the whole family seemed to draw closer to the mother and her son.

The last person to go over the scene of the disaster was Nadia. She was not only the most emotionally affected, but also the one best able to verbalise and express emotions in tune with the gravity of the situation. United, the family followed Nadia's retracing of her steps at the time of the tragedy. At the end of the re-enactment, Nadia said that she felt more comforted, she thought it was important to try to talk about what happened.

The counsellor thanked the family, stressing how important it was for everyone to have retraced their movements at the time of the critical event. He pointed out that the family now seemed more compact, including in terms of proxemics.

Phase 4 – follow-up

Follow-up with the Esmail family at two weeks and three months after the intervention was implemented by the same counsellor. At both meetings, all family members reported having benefited from the intervention. After two weeks, the most important change reported was a renewed sense of family unity and reciprocal support. All family members reported feeling more comfortable about stating their distress and fear. One of the members, Ziad, asked for individual psychotherapy in order to elaborate the multiple traumatic experiences that had been part of his personal story even before the disaster. After three months, the family members had almost totally recovered from their symptoms. The only one continuing to suffer anxiety symptoms was Ziad who was still attending an individual psychotherapy programme. However, Ziad too reported an increase in subjective well-being after the intervention with his family.

Discussion

The objectives of family in vivo exposure sessions include encouraging family members to share their individual narratives, so that each can contribute to the co-creation of a family narrative, and to elaboration of the unique meaning of the family's experience and learning. The interaction between the family members re-enacts specific family based survival skills, thus helping the family to draw on the resources naturally available to them in adjusting to trauma. The literature on PTG and narrative approaches highlights the importance of familial meaning-making processes in adjusting to extreme traumatic experiences, prolonged stress and loss (Saltzman, Pynoos, Lester, Layne, & Beardslee, 2013). The combination of an in vivo exposure technique and sense-making activities enables activation of a collaborative process facilitating the production of family members' individual narratives, followed by the co-construction of a shared family narrative. As a result of this experience, family members progress towards greater cohesion and flexibility with enhanced communication and reciprocal trust and support. After the reframing intervention conducted by the counsellor, in which the mother and Ziad were able to come closer to each other again, Jamal appeared readier to accept the brother experiencing the greater difficulty and the whole family united more closely with the mother and son pair. A working alliance between the family unit and the counsellor appears to be the best way forward, with a view to eliciting positive communicational transactions and co-constructions among the family members (Figley, 1987, 1988, 1989).

The main changes, both in terms of the individual and in terms of the family system, took place during the re-enactment (Phase 3a; Figley, 1998). The individual was depathologised and re-connected to the gravity of the event and to his past: it was not Ziad who had a pathological disposition, but rather the stratification of traumatic events and the particular position he held in the family that made him more vulnerable.

The main advantage of extending exposure to the trauma to the whole family unit was not only to put the fears of each member into perspective, but also to reduce their fantasy of losing their loved ones or the catastrophic idea that a loved one is not going to make it. By reinforcing the group, individual fears are reduced, almost as though one family member had become the container for other members' fears.

Conclusions

The encouraging results obtained in the field suggest that more should be done to modelise reconstructive intervention with families in crisis situations. The key would be to coordinate the various steps in the protocol, adapting them to specific sociocultural contexts as appropriate.

The coping and mastering skills of each individual should be developed alongside those of the family as a whole and, increasingly, also with the involvement of the wider community (Boelen, van den Hout, & van den Bout, 2006). Meaning-making activity is aimed above all at building confidence in the manageability and coherence of experience which in turn leads to a sense of confidence in the ability to understand and manage the traumatic consequences of war and violence (Antonovsky & Sourani, 1988; Saltzman et al., 2013).

In light of the goal to develop interventions that enhance individual and family resilience in war-affected populations, the clinical implications of the intervention may be summarised in the points outlined as follows:

- intervening in family transactions may allow the counsellor to reconnect to the family's past and future history the narrative plots interrupted and fragmented by the trauma, to promote the resilience of each individual family member and to control for any risk factors by personalising the intervention (Weine et al., 2006);
- narrating and reconstructing the significance of the traumatic event may exploit the salient narrative elements of the family's micro-culture to rebuild the fragmented perceptive and emotive field of both individual members and family unit (Sveaass & Castillo, 2000);
- working with the family may help to workout mastering and coping strategies for reconnecting with the macro-context (community), therefore, encouraging the traumatised members to return to their social context (Everly & Mitchell, 1997);
- working with the family may be an effective means of treating the post-traumatic reactions of children that are influenced by the reactions of their parents or of other adults, and may enhance the benefits of intervention in adults with acute trauma and post-traumatic symptoms (Dyregrov & Yule, 2006; Ruzek & Watson, 2001);
- eliciting peoples' narratives of the trauma (through the use of metaphors, stories and psychoeducational examples) may help to reduce symptomatic reactions and trigger a process of elaborating grief and adapting to loss (Neimeyer, 2006; Norman, 2000); and
- using processes of meaning-making alongside behavioural techniques, which have a positive effect on symptoms of avoidance, anxiety and depression, may contribute to preventing stress, enriching and triggering the elaboration of grief, restoring courage, competence and hope (Bousquet Des Groseillers et al., 2006).

The main limitation of the current research is the absence of a systematic assessment of the process and its outcomes. At the moment, our model is limited by the practical constraints that emerge in crisis and emergency contexts and by the particular isolation of Israeli/Palestinian society; it is still not sufficiently attentive to the involvement of the community, which remains, in our opinion, one of the main protective factors in the development of post-traumatic reactions (Weine et al., 2006). One future development of the model could be to increasingly engage community representatives, such as religious leaders, teachers and other key figures, in the intervention, along with the family (Miller et al., 2006). As things currently stand in the specific context in which our intervention was tested, the solidarity of the Palestinian community living inside the state of Israel is jeopardised by the fragmented fabric of Arab society and by the cultural impoverishment imposed by the Zionist institutions. One of the consequences of the cultural deprivation to which Israeli Arabs are subjected is the non-feasibility of any systematic intervention with the community, particularly in emergencies or crises. At certain levels, the family thus becomes the privileged place for intervention: a first step towards an ambitious and apparently remote goal of rebuilding a 'deprived' and depersonalised social fabric, gradually but systematically stripped of its own identity.

Another aim of intervention is to repair or reconstruct any channels of communication between different members of the family that have been disrupted by the traumatic event, thereby counteracting silence, implicit and explicit derogatory labelling and criticism and incentivising cooperation and emotive participation (Tjersland et al., 2006; Woodcock, 2001).

The model proposed here helps to advance our understanding of trauma intervention by identifying a list of techniques and procedures that can mobilise resources of resilience and functioning in families affected by war trauma and by specifying ways in which families are able to adjust and adapt in the face of crisis, and thereby function in a resilient fashion. These insights, in turn, provide a guide for the design of future interventions promoting family positive functioning and resilience.

Future developments of this intervention model should involve tighter monitoring of the effectiveness of the model, through controlled and randomised trials (Heckman et al., 2007). Our future goal is to gather empirical evidence on our model of crisis intervention with the involvement of the whole family in order to confirm the encouraging results recorded in practice in the field.

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