# The Association Between Exposure to Soldiers' Combat Trauma and Posttraumatic Stress Symptoms in Military Health Professionals: A Survey of IDF Combat Stress Reaction Unit Therapists


## Abstract

**Background**: The October 7, 2023, war significantly impacted Israeli mental health therapists, particularly those exposed to soldiers' military trauma. Identifying risk and resilience factors is critical for preventing the development of post-traumatic stress symptoms among therapists treating soldiers with military trauma.

**Methods**: An anonymous online survey was conducted among 33 therapists serving as reservists in the IDF Combat Stress Reaction Unit and treating soldiers (including reservists) who participated in the war. The survey included four self-report questionnaires, measuring the therapists' exposure to soldiers' description of their military trauma (Exposure to Combat Scale), post-traumatic stress symptoms (PTSD Checklist – PCL 5), self-efficacy (Generalized Self-Efficacy Scale), and resilience (Brief Resilience Scale). Statistical analyses included descriptive statistics, correlation analysis, and generalized linear models.

**Results**: Thirty-three therapists participated in the study (51.5% male and 48.5% female), 46.4% with 11-34 years of professional experience. Over 90% were exposed to soldiers' description of their military trauma (e.g., events of hand-to-hand combat, exposure to bodies or human remains, acquaintance with someone killed or seriously injured), and 30.3% reported post-traumatic symptoms (PTSS) — primarily arousal and reactivity, and intrusive thoughts. No significant association was found between the degree of exposure to the soldiers' trauma and therapists' PTSS. However, the risk of PTSS increased 71-fold in therapists who are parents to soldiers who participated in the war (12% of the sample). High resilience levels were a significant protective factor.

**Conclusions**: Therapists exposed to soldiers' traumatic combat experiences need professional support, particularly those with children who were soldiers in the October 7 war.


**Keywords:** post-traumatic stress symptoms, war events; therapists' exposure to soldiers' combat events, military trauma, combatants.

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## 1. Introduction

Treating trauma victims exposes therapists to traumatic content, which may impact their mental well-being and professional effectiveness [1-3]. The research literature distinguishes between two main phenomena: secondary traumatic stress and vicarious traumatization. While these terms are occasionally used synonymously, they signify distinct processes and outcomes [4]. Secondary traumatic stress describes a phenomenon in which therapists develop symptoms similar to post-

traumatic stress disorder (PTSD) as a result of exposure to trauma experienced by others, even though they were not directly exposed to a life-threatening situation themselves. Working with traumatized individuals requires therapists' emotional involvement, which increases their risk of secondary traumatization and suffering from secondary traumatic stress [1,4]. These symptoms include hypervigilance, avoidance, and emotional numbing [4]. While secondary traumatization manifests in symptomatic responses similar to PTSD, vicarious traumatization involves deep and lasting changes in the therapist's world perception, beliefs, and coping methods [1]. This study focuses on secondary posttraumatic stress symptoms (PTSS).

Key risk factors for PTSS in therapists treating individuals with PTSD include cumulative exposure to traumatic content, low tolerance for ambiguity, and a high workload with trauma cases, as identified in studies of social workers [3,5] and other therapeutic helping professionals [6]. A systematic review by Greinacher et al. [7] reinforces the finding that cumulative exposure to traumatic events constitutes a significant risk factor for PTSS, especially when exposure includes a wide range of traumatic content in a short period, as may occur in emergency and war situations. However, protective factors, such as social support and resilience, can prevent the onset of PTSS among mental health professionals [3,7]. Resilience, a sometimes amorphous concept, is often defined as the ability to recover or "bounce back" from challenging circumstances. Resilience is a common response to adversity [8], drawing on psychological constructs, cognitive traits, behaviors, and circumstances, among others, and is a measurable phenomenon. Factors contributing to resilience among mental health professionals, first responders, and various emergency personnel include dedicated professional training, regular supervision, and social and professional support systems. These serve as protective factors, reducing the risk of developing PTSS [2,7,9].

A study among 223 Israeli therapists treating October 7 survivors and their families examined their professional well-being, which included satisfaction, compassion fatigue, burnout, and secondary traumatic stress. The study found that 83.6% of therapists exhibited moderate levels of PTSD symptoms, 44.7% exhibited moderate levels of burnout, and 64.8% exhibited moderate-to-high levels of satisfaction [10]. Those treating bereaved families and families of hostages reported higher anxiety and PTSS [10]. Several studies were conducted during the October 7 war among Israeli therapists who had been exposed to traumatic events experienced by their patients. One study of 73 therapists found that 18% scored above the threshold on a questionnaire assessing post-traumatic symptoms, suggesting a high probability of PTSD. The researchers discovered that empathic concern and fantasy moderated the relationship between the therapists' exposure to difficult content during treatment and the severity of their PTSD symptoms [11]. A qualitative study conducted between December 2023 and March 2024 among 25 experienced (average 10.8 years) psychologists and social workers in mental health practice found that participants experienced secondary trauma that manifested in emotional detachment, physical symptoms, and arousal and reactivity. However, they also derived deep meaning and satisfaction from their work, contributing to their personal and professional growth [12]. In a study of 60 mental health therapists (75% women) from the Sderot Resilience Center, one year after October 7, PTSS was associated with increased stress. Finding meaning in work was associated with lower stress when secondary trauma symptoms were low or moderate, but not when they were high [13].

Secondary traumatization, or the development of PTSS among mental health professionals, is a phenomenon that is much less widely researched than direct traumatization. This is particularly true among military mental health professionals who are exposed to soldiers' military traumas.

Among the latter, symptoms can be more complex when the therapists themselves have been directly exposed to the same traumatic events, a phenomenon called shared traumatic reality [2]. In one study, therapists' direct exposure to the same traumatic event (or a different one within the same context) was associated with higher levels of PTSD, whereas indirect exposure (through their patients) was associated with distress and emotional exhaustion [14]. Such double exposure is likely in the case of large-scale or nationwide events,

such as the October 7 events and the war.

In the current study, we sought to examine whether there is an association between therapists' exposure to soldiers' military traumas and post-traumatic stress symptoms (PTSS), specifically among therapists treating these soldiers within active reserve duty in the IDF Combat Stress Reaction Unit (CSRU). A study conducted after the October 7 attack highlighted that Israeli mental health professionals view their work as a civic duty, referring to it as their personal "Tzav 8", a term borrowed from the military emergency call-up notice. This perspective is rooted in cultural values of solidarity and national responsibility [15]. Additionally, we also sought to determine whether the CSRU therapists feel confident treating soldiers who participated in the October 7 war, as well as their confidence in the focused trauma therapy (FTT) tools available to them. Research among Israeli military mental health professionals shows that faith in their professional capabilities and tools, as well as social support, are protective factors against post-traumatic symptoms and contribute to resilience [16].

Studies of evidence-based FTT tools indicate that they are safe and effective for PTSD, even with comorbidity with conditions such as depression or anxiety [17]. The FTTs found effective are cognitive processing therapy (CPT) [18], eye movement desensitization and reprocessing (EMDR) [19], prolonged exposure (PE) [18], and written exposure therapy (WET) [18]. In the U.S., these are first-line treatments as per Veterans Affairs VA)/Department of Defense (DoD) guidelines, since they demonstrate the strongest evidence for PTSD treatment in soldiers [20]. Nevertheless, there is a gap between the documented effectiveness of evidence-based FTTs and their comparatively low use among therapists trained in these tools [18], suggesting a lack of confidence.

**Note**: For clarity, the therapists surveyed were active reservists, i.e., called up for reserve duty as therapists in the CSRU. Similarly, the soldiers they treated within the unit were also reservists at the time of treatment, regardless of whether they had participated in the October 7 war as mandatory-service soldiers or emergency reservists.

Following the above, the research hypotheses are as follows: (1) An association will be found between the number of exposures to soldiers' traumatic events and the therapists' post-traumatic stress symptoms (PTSS). The association will be positive, i.e., the more exposure events a therapist experiences, the higher the number of symptoms they will experience; (2) An association will be found between the therapists' professional experience and their level of confidence in using FTT tools in treating soldiers for military trauma from the October 7 war. The association will be positive: the stronger their confidence in their professional capabilities, the more confident they will be in using FTTs.

## 2. Method

### 2.1. Study participants

This cross-sectional study involved 33 military mental health professionals working as therapists in the CSRU (as reservists within "Tzav 8" emergency call-up), treating reserve soldiers who are suffering from military trauma after participating in the October 7, 2023, war (whether as reservists or mandatory-service soldiers). The demographic and background characteristics of the participants are shown in Table 1.

### 2.2. Design, procedure, and materials

We based our cross-sectional retrospective survey on 33 therapists who served as emergency-call-up ("Tzav 8") reservists in the CSRU between October 7 and the end of April 2025. The online survey, including four self-report questionnaires and background information, was sent to the therapists' mobile phones; responses were anonymous. The survey was created in advance for staff use to assess whether the mental health team needed support during their work. Participation in the survey that formed the basis for this study was voluntary and anonymous. Because the survey was not originally intended for research, it was not submitted to the Institutional Review Board Committee; however, the study received IDF approval for publication.

### 2.3. Measures

**Background variables**

The demographic details collected included gender, age, country of birth (Israel/other), religion (secular/religious), children's participation in the war as soldiers

(yes/no) during the period of the therapists' military work, professional training (psychotherapist/ MSW/ psychologist intern/ specialist psychologist), number of years of professional experience as practitioners, and years of experience in the CSRU.

### 2.3.1. Independent variables

**Exposure to Combat Scale** [21]: The therapists' exposure to the soldiers' military trauma was measured through the Exposure to Combat Scale questionnaire that includes 18 statements (items) related to war experiences, based on combat experiences reported by U.S. Army and Marine Corps soldiers deployed in Iraq or Afghanistan. The answers to all are dichotomous (yes/ no). In the current study, we asked therapists the same 18 questions we routinely ask soldiers to assess the number and nature of the events they experienced. The responses to the 18 statements were scored by summing up the number of exposures per participant, and in addition, the mean exposure and standard deviation (SD) were calculated for the entire sample. The data of the current study revealed high internal consistency for the entire scale (Cronbach's $\alpha = .90$).

**FTT** – The CSRU employs various therapeutic tools that are considered the gold standard in trauma treatment [17-20], including prolonged exposure therapy (PE), cognitive processing therapy (CPT), cognitive behavioral therapy (CBT), eye movement desensitization and reprocessing (EMDR), and written exposure therapy (WET). Additionally, and bearing in mind that the surveyed therapists were serving as called-up reservists, we note that most therapists in general practice are trained in dynamic treatment, with those specializing in trauma (in civilian or military settings) receiving additional specialized training. Additionally, for the past three years, the CSRU has been providing supervision in FTT, specifically in EMDR and WET. In this study, we asked therapists a single question about their confidence in using FTTs with the soldiers they were treating. The questionnaire uses a ten-point Likert scale, ranging from 1 ("not at all confident") to 10 ("very confident").

**Generalized Self-Efficacy Scale** – The self-efficacy variable was measured using the Generalized Self-Efficacy Scale (GSES), which assesses the strength of individuals' belief in their ability to respond to and manage challenging events or obstacles affecting their environment and lives [22]. The questionnaire consists of 10 items, each using a four-point Likert scale. The current study's data revealed high internal consistency throughout the scale (Cronbach's $\alpha = .81$).

**The Brief Resilience Scale** – The resilience variable was measured using the Brief Resilience Scale, a questionnaire designed to assess the ability to bounce back from an adverse or stressful event [23]. The questionnaire consists of six items (e.g., "I tend to bounce back quickly after hard times"; "I have a hard time making it through stressful events"; "It does not take me long to recover from a stressful event"), using a five-point Likert scale, with answers ranging from "strongly disagree" to "strongly agree". The current study's data revealed high internal consistency throughout the scale (Cronbach's $\alpha = .62$).

**Professional Support Systems** – We asked one question to assess satisfaction with the maintenance of the care team's well-being: "Please rate your level of satisfaction with the professional maintenance of the care team's well-being concerning the various trainings". The 'various trainings' referenced were those provided by the CSRU, specifically, training for FTTs, individual and group supervision, and team meetings (i.e., professional support). The questionnaire uses a ten-point Likert scale, with 1 indicating "not at all satisfied" and 10 "very satisfied."

### 2.3.2. Dependent variable

**Post-traumatic Stress Symptoms (PTSS)** were examined using the PTSD Checklist – PCL-5 [24]. This twenty-item questionnaire relates to four symptom clusters congruent with those of the DSM-V: re-experiencing, avoidance, negative alterations in cognition and mood symptoms, and alterations in arousal and reactivity. The PCL-5 is designed to be administered using the standard instructions that explicitly guide participants to anchor their responses to the "worst event" they have experienced. In this

survey, participants were instructed as follows: "Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping the worst event you have been exposed to in mind, please read each problem carefully and then select one of the numbers on the right to indicate how much you have been bothered by that problem in the past month." Additionally, we did not use the tool's standard 0-4 scale because we initially intended the survey to be used for professional support purposes.

The DSM-5 PTSD definition comprises a variety of symptoms that fall into four clusters: re-experiencing (e.g., repeated, disturbing dreams of the event), avoidance (e.g., avoiding memories, thoughts, or feelings related to the event), negative alterations in cognition and mood (e.g., blaming oneself or someone else for things that relate to the stressful experience), and alterations in arousal and reactivity (e.g., difficulty concentrating) [24]. Our goal was to understand which PTSD clusters were common and how they were distributed. Thus, the items were rated on a dichotomous scale (yes/no). The data of the current study revealed high internal consistency over the entire scale (Cronbach's $\alpha = .77$).

### 2.4. Statistical Analysis

Data analysis was performed with SPSS (version 30.0; Armonk, NY: IBM Corp) . Statistical significance was set at $p < .05$. We used descriptive statistics to present the study participants and the main study variables (means and standard deviations for continuous variables and distributions for categorical variables [%, N]). To evaluate the differences between background variables in PTSS we used the Kruskal-Wallis and Mann–Whitney (Wilcoxon W) tests. Spearman's rank correlation was used to examine the association between the research variables. Finally, we performed a Generalized Linear Models-GLM to examine relationships and predictors of PTSS.

## 3. Results

Of 33 therapists, 51.5% were male and 48.5% female, with a mean age of 40.52 years (SD = 6.20; median = 39.00; age range 31-60). Their professional experience ranged between one and 34 years (average 11.77 years), with 70.0% having one to two years of experience in the CSRU. About half of the therapists (46.4%) had 11-34 years of professional experience. Finally, four therapists, representing 12.1% of the study population, had at least one child who served in the war while they were employed as therapists with the CSRU. Table 1 presents the categorical descriptive statistics.

Hypothesis 1 suggested that a positive association would be found between the number of exposures to the soldiers' traumatic events and the therapists' post-traumatic stress symptoms, meaning the more

| | | N | % |
|---|---|---|---|
| Gender | Male | 17 | 51.5 |
| | Female | 16 | 48.5 |
| Country of birth | Israel | 27 | 96.4 |
| | Other | 1 | 3.6 |
| religion | Secular | 25 | 80.6 |
| | Religious | 4 | 12.9 |
| | Traditional | 2 | 6.5 |
| One of the children's participations in the war | Yes | 4 | 12.1 |
| | No | 29 | 87.9 |
| Professional training | Psychotherapist | 10 | 30.3 |
| | Masters in Social Work | 14 | 42.4 |
| | Psychologist Intern | 5 | 15.2 |
| | Specialist Psychologist | 4 | 12.1 |

**Table 1** - Descriptive Statistics

exposure to traumatic events a therapist experiences, the higher the number of symptoms will be. This hypothesis was not confirmed. Although the mean number of therapists' exposures to soldiers' traumatic events was high, with 13.73 items (SD = 4.38; range 0-19), the number of PTSS as measured by PCL-5 was relatively low, with each therapist experiencing at least two symptoms (SD = 2.48; median = 1.0; range 0-11). Specifically, p = .105, which indicates a weak significance of a direct relationship; however, this relationship is not considered significant. Therapists were exposed to a wide range of traumatic events through their patients. An exceptionally high proportion (90% or more) were exposed to events of soldiers coming under artillery, rockets, or mortar fire, exposure to bodies or human remains, knowing someone seriously injured or killed (93.9%, respectively), and exposure to dead or seriously injured IDF soldiers (90.9%). In addition, 75.8% were exposed to a soldier's experience of being involved in the death of an enemy combatant, and 45.5% to soldiers involved in the death of a noncombatant.

## Distribution of Post-Traumatic Cluster

Overall, although the results showed that arousal and reactivity, as well as re-experiencing symptoms, were prominent, few therapists reported negative alterations in cognition and mood, or in the avoidance cluster. Nearly one third (30.0%) reported arousal and reactivity — specifically hypervigilance; 24.2% reported concentration difficulties, 21.2% reported exaggerated startle response, and sleep disturbances. Regarding intrusive thoughts, 24.2% reported experiencing distressing, recurring, involuntary, and intrusive memories of the event described to them, and 12.1% reported intense psychological distress when exposed to stimuli symbolizing the event. Of note, 30.3% (n = 10) reported not experiencing any of the post-traumatic stress symptoms.

## Relationship Between Research Variables

Among all the variables — exposure, post-traumatic stress symptoms, self-efficacy, resilience, age, years of professional experience, and years with the CSRU — Spearman correlations revealed a positive correlation only in self-efficacy. Self-efficacy was positively correlated with resilience (r = .353, p = .044), age (r = .414, p = .021), and professional experience (r = .377, p = .040), indicating that higher resilience is associated with greater self-efficacy. Similarly, self-efficacy has been shown to increase with age and with years of professional experience.

## Predicting Post-Traumatic Stress Symptoms (PTSS)

The study identified several variables that predict PTSS in the sample (Table 2). These include being born in Israel (OR = 335.073; 95% CI: 6.228–17855.865, p = .004) and being a parent of a soldier participating in the war (OR = 71.428; 95% CI: .522–.000, p = .021). Additionally, higher resilience levels were protective, as indicated by a regression coefficient of -1.312 (OR = .269, 95% CI: .073–.997, p = .049). In absolute numbers, only one of the therapists was not born in Israel; four were parents of soldiers serving in the war.

## Confidence in Treating Soldiers With Military Trauma From the October 7 War, and Confidence in Use of FTTs

**Confidence in treating soldiers with military trauma from the October 7 war.** Overall, the average for the entire sample indicates a high level of confidence in treating soldiers with military trauma from the October 7 war (average 7.33 on a scale of 1-10).

**Training and Certification in FTTs.** Most therapists (75.8%) were certified in EMDR, approximately half (51.5%) in WET, and approximately one-third (33.3%) in CBT. Less than 10% of therapists were certified in PE (9.1%) and CPT (0.3%), despite these being regarded as leading evidence-based FTTs in trauma treatment effectiveness. Additionally, a high percentage (60.6%) were certified in dynamic therapy within their general practice outside the CSRU.

**Confidence using FTTs in treating soldiers with military trauma from the October 7 war.** Hypothesis 2 suggested that a positive association will be found between the therapists' professional experience and their level of confidence in using FTT tools in treating soldiers for military trauma from the October 7 war,

| | | B | Wald | Likelihood ratio test (LRT) | *df* | Exp(β) | 95% Confidence Interval | | *p* | *p* (LRT) |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Low | High | | |
| Intercept | | 7.740 | 10.923 | 1.560 | 1 | 2298.207 | 7.216 | 731997.236 | <.001 | .212 |
| Gender | Male | -.644 | 1.279 | 1.249 | 1 | .525 | .172 | 1.604 | .258 | .264 |
| | Female | | 0[a] | | | 1 | | | | |
| Country of birth | Israel | 5.814 | 8.216 | 7.173 | 1 | 335.073 | 6.288 | 17855.865 | .004 | .007 |
| | Other | | 0[a] | | | 1 | | | | |
| religion | Secular | 1.626 | 3.429 | 3.228 | 1 | 5.084 | .909 | 28.428 | .064 | .072 |
| | Religious | | 0[a] | | | | | | | |
| One of the children's participations in the war | Yes | 4.296 | 5.335 | 4.868 | 1 | 71.428 | .522 | .000 | .021 | .027 |
| | No | | 0[a] | | | | | | | |
| Professional seniority | | -.157 | 3.504 | 3.295 | 1 | .855 | .726 | 1.007 | .061 | .069 |
| Seniority in the CSRU | | .111 | 1.163 | 1.139 | 1 | 1.118 | .913 | 1.368 | .281 | .286 |
| Resilience | | -1.312 | 3.858 | 3.606 | 1 | .269 | .073 | .997 | .049 | .058 |
| Self- self-efficacy | | -.549 | .330 | 0.328 | 1 | .578 | .089 | 3.756 | .566 | .567 |
| Exposure to Soldiers' Combat Traumas | | .006 | .007 | 0.007 | 1 | 1.006 | .881 | 1.149 | .931 | .931 |

**Note**: Generalized Linear Models

**Table 2** - Predicting post traumatic symptoms

meaning that the stronger their confidence in their professional capabilities, the more confident they will be in using FTTs. This hypothesis was partially confirmed. First, dynamic therapy showed the highest confidence level compared to FTTs (which they are trained in). Second, 81.3% of therapists reported high or very high confidence in using various FTTs, despite only 60.6% reporting formal certification in these tools. Third, among all FTTs, therapists reported the highest confidence in using WET, with 61.6% reporting high or very high confidence, although only 51.5% were certified in the method. Conversely, although most therapists (75.8%) were certified in EMDR, only about 22.2% reported high or very high confidence in its implementation. Half of the therapists (51.9%) reported moderate confidence in using it.

Finally, the number of years of professional experience was found to have a positive correlation with confidence in EMDR treatment ($r = .542$, $p = .006$), CBT ($r = .452$, $p = .039$), as well as with confidence in treating soldiers with military trauma from the October 7 war ($r = .596$, $p < .001$).

## Professional Support Systems

Among the training and support provided by the CSRU to therapists' work and well-being, therapists reported high satisfaction with team meetings, individual and group supervision, and specialized training in EMDR and/or WET. Individual supervision is perceived as the most significant support resource (88% reported that it contributes greatly), alongside team meetings and group supervision (80% reported that these contribute greatly).

Finally, we should mention that the overall self-efficacy among the sample group is high, with a mean score of 3.36 (SD = 0.391; median = 3.5; range 2.5-4.0). Additionally, the mean level of resilience is also high, at 3.62 (SD = 0.471; median = 3.66; range 2.83-4.67).

# 4. Discussion

In the current study, we sought to examine whether CSRU therapists' exposure to the traumatic events

experienced by the reservists they were treating for military trauma typically led to PTSS. We also sought to examine whether they feel confident treating soldiers who participated in the October 7 war and confident in the professional FTT tools available to them. We hypothesized that the more exposure events a therapist has experienced, the higher the number of post-traumatic stress symptoms would be. Additionally, we expected that the stronger therapists' confidence in their professional capabilities, the higher their confidence in using FTTs.

Overall, our study did not reveal a statistically significant association between the therapists' exposure to the soldiers' traumatic event/s and PTSS. However, the likelihood of PTSS increased dramatically (71-fold) among therapists who were the parents of a soldier who participated in the war while they were working in the CSRU, although only four (12%) were in this category. While this is a small absolute number and therefore generalizability may be limited, we have no point of reference, as this phenomenon has not been studied. This may merit a future study with a larger sample size of therapists who have treated military trauma while being the parent of a soldier in wartime, to examine the correlation between this situation and post-traumatic stress symptoms — particularly in Israel, where this is a relatively likely set of circumstances compared to other settings.

Among the general population of parents of soldiers (and prior to the war), a study examining 202 Israeli parents between January and September 2023 found that nearly one quarter (22.8%) of parents experienced distress, defined as having high depression, anxiety, or stress scores. The nature of the children's military service affected the parents' attitudes. Specifically, combat service (vs. non-combat) was significantly associated with distress: parents of combat soldiers were four times more likely to report distress than parents of non-combat soldiers. In addition, highly classified positions preventing the child from sharing information with the parents was significantly associated with parents' distress [25].

As noted, this study did not find a significant relationship between therapists' exposure to soldiers' trauma event/s and PTSS. In this context, however, the study found that higher therapists' resilience was a protective factor against developing such symptoms. Still, post-traumatic stress symptoms are clearly evident in the therapists' responses to the PCL-5 questionnaire, especially in the re-experiencing and arousal and reactivity clusters (mainly hypervigilance, concentration difficulties, exaggerated startle response, and sleep disturbances). These symptoms align with the definition of secondary traumatization [4] and indicate that even without direct exposure to the traumatic event, therapists experience physical and emotional reactions similar to those of their patients. Interestingly, the negative cognitions and mood cluster remained essentially unchanged. These findings are compatible with research conducted among complementary medicine therapists (N = 118) working in hospitals, which found that 12.7% had symptoms of secondary traumatization, with clinical levels of re-experiencing, arousal, and reactivity, and avoidance symptom clusters [26].

Finally, compared to the soldiers' rates of exposure to traumatic events during the war as reported upon intake to the CSRU, the mean exposure of therapists was almost twice as high as that of soldiers treated in the unit at the same time. The mean number of exposures among 806 reservists who sought help from the CSRU was 6.514 [27]. Further research and comparative analysis of the exposure rates of CSRU patients and therapists may shed light on the phenomenon of secondary traumatization among therapists treating military trauma in the unit.

Regarding hypothesis 2, which suggested that the stronger therapists' confidence in their professional capabilities, the higher their confidence in using FTTs would be, the study found that therapists reported the highest confidence in dynamic therapy rather than in FTTs. On the one hand, 81.3% of therapists reported high or very high confidence in dynamic treatment (which most are trained in within general practice). On the other hand, although most therapists (75.8%) were certified in EMDR, only about 22.2% reported high or very high confidence in implementing the method, and only half of therapists (51.9%) reported moderate confidence in its use. These findings indicate that therapists have difficulty using FTTs. When asked about considerations

for using one method or another, therapists noted that FTTs pose challenges in establishing a close and empathetic relationship, managing tensions during sessions, helping patients connect with deep emotions, and encouraging exposure and sharing. However, the confidence level in treating soldiers with military trauma from the October 7 war is high, as is the confidence level in the FTT tools available to the therapists.

Among FTTs, the majority reported certifications in EMDR (75.8%) and WET (51.5%). They expressed high confidence in the use of WET (61.6%) and the highest confidence in dynamic therapy (81.3%), despite dynamic therapy not being a first-line treatment for combat casualties. Research indicates a significant gap between the proven effectiveness of gold standard focused trauma therapies, such as PE and CPT, and therapists' confidence in using them. This finding is consistent with professional literature [28], which suggests that therapists often do not utilize evidence-based treatments, even though they are effective. The disparity between certification rates and confidence levels in this study — especially notable in EMDR — raises questions about the effectiveness of the training programs. One possible explanation is professional experience: 46.4% of therapists had considerable experience (11 to 34 years), which may foster openness to adopting methods such as EMDR and WET. Furthermore, the study found that the EMDR and WET training provided by the CSRU, combined with weekly supervision, significantly boosts confidence and implementation rates (91.3%). This underscores the importance of targeted professional development in enhancing therapists' skills and confidence. Supervision emphasizes the importance of professional support systems for trauma therapists. In the current study, therapists reported individual supervision as the most significant support resource (88%), followed by team meetings and group supervision (80%). These systems are critical for combining individual guidance, group support, and continuous professional development, particularly in acquiring trauma-focused and evidence-based methods. In emergency contexts, such systems are essential not only for treatment quality but also for preventing secondary traumatization among therapists [29]. Research supports this finding: Baird and Kracen et al. [4] highlight the role of professional supervision in reducing traumatic effects, Greinacher et al. [7] emphasize the need for support systems for emergency teams, and Baum et al. [8] found that trained therapists reported fewer shock, flooding, avoidance, and detachment symptoms while experiencing greater meaning and satisfaction in their work.

## Summary

The research findings emphasize the complexity of the CSRU therapists' work during the war. The extensive exposure to traumatic content, the gap between recommended treatment methods and field practice, as well as that between the confidence in these tools and their actual use, and the need for professional support systems attest to the unique challenges in this field.

The surveyed therapists show a clear preference for EMDR, WET, and dynamic therapy methods, both in training and in confidence. These may be perceived as more effective or easier to implement in the specific context of treating military trauma. Additionally, this may be attributed to the training and close supervision provided in CSRU for both methods.

## Study Limitations and Recommendations

This study has several limitations. First, the sample size (33) limits the ability to draw statistically significant conclusions. Second, the data are based on self-report, which may introduce bias. Third, the study was conducted at a specific time point, without comparison to the pre-war situation or longitudinal follow-up. Fourth, we used PCL-5 as a dichotomous variable; we did not use the tool's standard 0-4 scale because we initially intended to survey for professional support purposes and not for research on secondary traumatization.

In addition to the findings discussed in this article, the relatively small sample size (for a quantitative study) suggests the need for further research. A follow-up qualitative study involving in-depth interviews with the therapists who treated soldiers with military trauma during the war could provide valuable insights.

Finally, it would be beneficial to expand the existing range of FTTs available to CSRU therapists to include CPT and PE training, and to provide close accompaniment and supervision in these as well, since we observed

that training in the unit, along with close supervision, contributes to the therapists' sense of confidence in using a specific treatment method.

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