

WG 3 (Psychological health)

### **Combat Guilt: Combatants' Trauma-Related Guilt, Psychotherapy and Psychotherapists Transference**

**Yossi Mitz.**

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Guilt is a common phenomenon among people who have experienced traumatic events, despite being victims themselves. Combatants who have experienced traumatic events during combat often feel guilty regarding various aspects of the event: their functioning or disfunction in the events, their emotional response, or the very fact that they are alive. Studies have shown that trauma-related guilt is especially common among soldiers seeking treatment, and in some studies, it was found that 41% of soldiers reported feeling guilty in the month preceding the measurement. That guilt – even when it's not part of PTSD – can be experienced for years as a rigid, torturous experience and perception that the combatant deserves punishment and suffering.

In the lecture, I will review the theoretical background for trauma-related guilt, in psychoanalytic thinking as well as from the perspective of cognitive psychology, and valid therapeutic models. I will refer to the unique features of trauma-related-guilt in combatants, and I will propose a new conceptualization - 'combat guilt'.

Through a case study from group intervention with combatants, I will present an application of these unique features of combat-guilt for therapeutic practice, by recognition and processing of the combatant relationship with the affiliation group (squad, platoon etc.).

In addition, I will refer to aspects of countertransference of guilt among combat-trauma therapists, and its effect on the therapeutic process.

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### **The Activity of the Rear Rehabilitation Unit in the Iron Swords War – From Theory to Reality**

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On October 7, the Rear Rehabilitation Unit received (MALSHA) orders to commence operations. This reserve unit is activated in emergencies (war), and its mission is to treat soldiers no longer in the front lines suffering from Acute Stress Reactions (ASR) or Disorder (ASD) following operational activities. The first time activated since 1982, in the weeks and months following October 7, the unit faced a series of challenges: the number of patients was five times greater than the planned maximum capacity; the principles of Closeness, Immediacy, and Expectancy (CPI), which are the military's basis for treating ASR and ASD, did not fit the unit's treatment framework; the patients and families experienced a lack of trust and a feeling of abandonment; and there was a need to implement an overall uniform therapeutic approach among a diverse population of veteran therapists, all of whom were reservists. In this talk, I will describe how we addressed these challenges during the unit's operational period focusing on: 1. Alternatives CPI, balancing regression with the option to return to active duty if at all possible; 2. Addressing the soldiers' need for security and containment while simultaneously exposing them to the ongoing military reality; 3. Providing a uniform approach for treatment without undermining the therapeutic identity of the therapists and their professional freedom, acknowledging that therapeutic flexibility is essential in treating the ASD phase.

I will conclude by referring to the uniqueness of the Rear Rehabilitation Unit as a military therapeutic body that treats soldiers suffering from trauma within the military system, and the inherent tension between the need to encourage the traumatized soldiers for regression and return to functioning. The statistic that more than 80% of the soldiers returned to service supports the assumption that encouragement toward regression did not significantly harm the soldiers' return to military service.