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ORIGINAL PAPER

"You can't choose these emotions… they simply jump up": Ambiguities in Resilience-Building Interventions in Israel

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Abstract Following the growing critique of the use of Post-Traumatic Stress Disorder in post-disaster interventions, a new type of intervention aimed at building resilience in the face of traumatic events has been making its first steps in the social field. Drawing on fieldwork of a resilience-building program for pre-clinical populations in Israel, we analyze the paradoxes and ambiguities entailed in three interrelated aspects of this therapeutic project: The proposed clinical ideology aimed at immunizing against traumas; the discursive and non-discursive practices used by the mental-health professionals; and, participants' difficulties to inhabit the new resilient subject. These contradictions revolve around the injunction to rationally handle emotions in response to disruptive traumatic events. Hence, the attempt to separate between a sovereign rational subject and a post-traumatic subject is troubled in the face of experiences of trauma and social suffering. Furthermore, we demonstrate how these difficulties reconstitute unresolved tensions between mimetic and anti-mimetic tendencies that have been pervading the understanding of trauma in the therapeutic professions. Finally, we discuss how the construction of the resilient subject challenges the expanding bio-medical and neoliberal self-management paradigm in mental health.

Keywords Post-Traumatic Stress Disorder · Resilience · Therapeutic interventions · Self-management · Israel

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Towards the end of the second meeting of a resilience workshop for teachers in a Jewish-religious (Hebrew 'mamlakhti-dati') elementary school[1] in a town in the north of Israel, Rosa, the facilitator, introduces one last exercise for the day.[2] It is late in the afternoon and it seems that the teachers, all religious-observant women, are losing their patience and want to go home. It was a very emotionally loaded meeting, since Dorit, one of the teachers, shared with the participants the stories of the killings both of her sister-in-law in a Palestinian terrorist attack and of her son-in-law in a military operation in Gaza. Rosa spreads sheets of paper and color pencils on the floor and asks the teachers to draw "where you feel you are right now." Some teachers start drawing, while others choose instead to talk with their friends about mundane school issues. After 10 minutes, Rosa asks everybody to sit back in the half-circle of chairs and discuss their drawings. The first teacher relates her drawing to the emotions aroused by Dorit's tragic story, adding how hard it is right now, after the disruption caused by the workshop, to "disconnect" and return to routine. Then Dorit bursts in:

> It was very difficult for me. I don't even know what I am going to say in my turn, and I think about a question mark, because I am trying to just repress it because you have to go on, so you try to put things aside. I find myself in a question mark, but I feel that everything came back to me now. I spoke and everything came back…
> **Rosa:** It's natural. This is where you are now. Where do you want to be?
> **Dorit:** Now? I would like to be some days ahead. Like getting out of this feeling. I need to let some days pass.
> **Rosa:** You really came back to it…
> **Dorit:** I came back to it, yes. Look, don't forget that last week was Remembrance Day (Hebrew 'Yom Hazikaron').[3] On Saturday I was there [at the cemetery]. This is already hard for us, all this situation. […] So I don't know where I am. I simply don't know where I am now. I am here, but I don't want to be here. I want to be some days ahead.
> [Later in the workshop]
> **Rosa:** Your story is very hard but it includes everything. […] It is very enlightening.
> **Dorit:** You see, it is enlightening first of all because Israeli society regretfully… there is bereavement all the time in this country. This is not a normal country, where people die when they get old; Here all is upside down. […] As my father used to say: 'I have to recite Kaddish[4] for my grandchild? He has to recite Kaddish for me, not me for him!' And this is a country where you hear all the time bereavement, bereavement, bereavement, but it is different when you are part of it. […]

[1] These are public schools that roughly adhere to a Jewish Zionist-orthodox ideology. The intervention program was deployed in all kinds of schools, including the so called secular ('mamlakhti') schools.

[2] All names of workshops facilitators and participants are pseudonyms.

[3] Israel's memorial day for fallen soldiers.

[4] A Jewish mourning prayer.

Rosa: But your coping, sorry that I get back to this, you did this with laughter, with humor. It is a nice coping. I am sorry that I am not letting you to go back there, because I don't want you to be there. I want to tell all of you, although it is really hard, Dorit's story included all the possible ways to cope with the situation.

These moments in the field expose a conflict between a pathological subject of trauma and a healthy subject of resilience. The latter is the ideal of a new paradigm in the field of trauma that recently has been making its first steps in the social field (Howell 2012; Young 2007). The teachers' questioning, and especially Dorit's outcry, demonstrates a momentary breach in the narrative fostered by the workshop, and the facilitator's (unsuccessful) attempt to contain it and restore the possibility of resilience. The workshop was supposed to empower and "immunize"[5] the participants (a non-clinical population) by giving them "tools" to actively cope with trauma, but Dorit and her peers seemed to adopt a fatalistic stance: You can do nothing against the sheer force of traumatic events, they seem to say. You just need to "repress" them and let time run its course.

How should we interpret this breach? What does Dorit's objection to the resilience narrative offered by Rosa tell us about this new type of therapeutic intervention? What can we learn from Rosa's replies and her efforts to restore the possibility of resilience? The answers to these questions speak to the social ambiguities, tensions and paradoxes involved in the attempt to construct a resilient subject by means of psychological interventions that are directed at pre-clinical populations.

At first sight, we can interpret the above exchange as an instance of the psychologization of "social suffering" (Kleinman et al. 1997). Thus, the facilitator is trying to impose a Western psychological view of suffering, while participants express their "resistance" by using a local idiom of distress known as "national trauma" (Friedman-Peleg and Bilu 2011; Plotkin-Amrami and Brunner 2015).[6] Such a scene is not strange to anthropologists of trauma, who in the past two decades have extensively documented how psychiatric and psychosocial interventions based on the concept of Post-Traumatic Stress Disorder (PTSD) medicalize and pathologize social suffering around the globe. This line of research underscores the individualizing and de-politicizing effects of these interventions, and points at local strategies of appropriation and resistance (Breslau 2004; Dwyer and Santikarma 2007; Fassin and Rechtman 2009; James 2004; Kleinman and Desjarlais 1995; Kleinman and Kleinman 1997). Still, the politics of suffering and its psychological handling should not be too rigidly opposed. For Dorit and her peers, for instance, popular psychological language is already an integral part of their 'native' cultural repertoire for understanding suffering. Resilience workshop

[5] In Hebrew, resilience ('hosen') and immunization ('hisun') share the same linguistic root, thus making the connection between these two concepts seem natural and necessary.

[6] "National trauma" aligns the divergent discourses of the therapeutic and the national by "weaving together emotional symptoms of individual psychopathology with cultural markers of collective experience and identity" (Friedman-Peleg and Bilu 2011:418). This concept was introduced by mental health experts in Israel and is becoming popularized, as exemplified in this excerpt.

participants are thus trying to negotiate their expression of emotional vulnerability rather than problematize the wider politics of suffering. Moreover, Rosa, the facilitator did not try to impose a traumatic narrative but dissuade Dorit from such a narrative by convincing her that she nevertheless succeeded in coping with the situation. The central issue at play is thus not just the psychologization of social suffering, but the elusiveness involved in embodying the position of the new resilient subject.

Resilience experts try to map and translate the emotional realm to fit their new notion of empowerment. In this article we explore how this new type of subject is constructed and negotiated in resilience-building interventions. We delve into the program's clinical ideology (Young 1995), and we examine the events, concepts and discursive and non-discursive practices used by these mental health professionals. We then point to difficulties, contradictions and uncertainties found in participants' attempts to inhabit the ideal resilient self, and ask what these ambiguities tell us about these evolving conceptions of trauma and subjectivity.[7]

Trauma, Subjectivity and the Self-management Paradigm

Writers of the cultural history of trauma, as well as its clinical and popular configurations, focused on the relations between trauma and subjectivity, for these relations betray core Western assumptions about agency and the self. "The discovery of traumatic memory," argued Young, "revised the scope of two core attributes of the Western self, free will and self-knowledge—the capacity to reflect upon and to attempt to put into action one's desires, preferences, and intentions" (1995:4). As Leys (2000) shows, the genealogy of trauma is marked by an uneasy tension between two antithetical theories. The first, termed the 'mimetic' theory, holds that trauma can be understood as an experience of hypnotic imitation (or unconscious identification) with the aggressor or the traumatic event. This violent experience "immerses the victim in the traumatic scene so profoundly that it precludes the kind of specular distance necessary for cognitive knowledge of what had happened" (ibid, pp. 8–9). The second, termed the 'anti-mimetic' theory, regards trauma as if it were "a purely external event coming to a sovereign if passive victim" (ibid, p. 10). The subject is "essentially aloof from the traumatic experience, in the sense that she remains a spectator of the traumatic scene, which she can therefore see and represent to herself and others" (ibid, p. 299). This latter theory has come to dominate the field in the last decades, as indicated by the adoption of the PTSD model, which underscores the role of the event in the syndrome, and the increasing interest in neurobiological theories of trauma.

Further, in the last 30 years, understanding trauma has shifted from a suspicion paradigm (and thus from a suspect condition) to a pathological paradigm, holding a legitimate status that excites public sympathy and merits compensation (Fassin and

[7] Our aim is descriptive and analytic. We do not offer a judgement on the intervention's effectiveness or its potential benefits or risks for citizens that participate in these activities. Evaluating the intervention efficacy is well beyond the scope of this article, as it requires different methodological and disciplinary approaches.

Rechtman 2009). The suspicion paradigm, which dominated military psychiatry during the two world wars, assigned a minor role to the external event in the etiology of the syndrome. Traumatized soldiers were not conceived as "ordinary men placed in extraordinary situations, as they would come to be seen in the second half of the twentieth century" (ibid, p. 63). The focus was instead why some individuals failed to cope properly with harsh events. Psychiatrists underscored the soldier's fragile personality, his faults and weaknesses and "all the factors that made him different from his comrades in arms" (ibid, p. 49). The psychoanalytic model, which came to dominate the treatment of so called 'traumatic neuroses of war,' deepened this emphasis on the problematic individual by focusing on the patient's unconscious conflicts. Trauma became an "internal force which, when it encountered certain events or fantasies, would produce the pathological manifestations described by psychiatric semiology" (ibid, p. 34).[8]

The first challenge to the suspicion paradigm came from the experiences of Holocaust survivors, followed by the recognition struggles of Vietnam War veterans, feminist activists, and rape and child abuse survivors (Fassin and Rechtman 2009; Hacking 1998; Young 1995). In the evolving new paradigm, epitomized in the concept of PTSD, "the traumatic experience was repositioned to become a testament to the unspeakable" (Fassin and Rechtman 2009:72). Rejecting the psychogenic approach to trauma, the traumatic event became the necessary and sufficient etiological agent of the disorder. The event was understood now as "outside the range of usual human experience," and the traumatic response was conceived as "a normal response to an abnormal situation" (ibid, p. 87).

In both Leys' (2000) and Fassin and Rechtman's (2009) accounts, two antithetical models of trauma and subjectivity are at work. In the first, the impact of the traumatic event (real or imagined) is mediated by the subject's psychological makeup, earlier experiences and unconscious processes. In the second, the external event takes precedence over the subject's personality and traits, which are deemed quite irrelevant for understanding the disorder.

The PTSD model of trauma rests on a strict separation between a sovereign subject and an external traumatic event, which according to the new clinical ideology is assumed to be the sole pathological agent. This model is in line with the dominant biomedical model in psychiatry that "presumes the isolability of personhood from pathology" (Weiner 2011:453) and thus "posits a stable and rational managing self who can observe, measure, anticipate, and preside over a disease separable from the self" (ibid, p. 452).

This type of subjectivity draws upon broader notions of a neoliberal entrepreneurial self, encompassing in particular responsibility, accountability, rationality and free choice (Rose 1996). This notion of a coherent, homogeneous and rational subject quickly runs, however, into deep conundrums. An example is found in the adoption of the self-management therapeutic paradigm to the treatment of bipolar disorder in which the patient is asked to make the disease an object of deliberate management (Weiner 2011). A whole set of contradictions arise in the

[8] On the suspicion paradigm and the role of military psychiatry in the construction of trauma see also Brunner 2002.

attempt to rationally manage a disease that calls the patient's rationality into question and when "provisional and distributed forms of agency based on an elusive, discontinuous, and only partially knowable or controllable self" are at work (ibid, p. 453).

Building on these theoretical challenges to biomedical reason, we demonstrate how the recent resilience paradigm in the field of trauma is modeled around the tensions between the mimetic and anti mimetic understanding of trauma, and between its older paradigm of individuals' psychological make-up and the newer PTSD model that underscores the impact of a pathological event. Further, we explore how the idea of self-management of mental illness reproduces the ambiguities embedded in the calculating and choosing subject of neoliberal governmentality. We thus inquire into the paradoxes emerging within the injunction to rationally manage the subject in the face of disruptive traumatic events.

The Resilience Project and Its Contexts

The central site of this ethnographic inquiry is the resilience unit at The Israeli Center for the Treatment of Psycho-trauma (ICTP), a leading NGO in the growing trauma field in Israel. The fieldwork, carried out by the first author intermittently between 2009–2012, included observations at a resilience workshop for teachers at a Jewish-religious elementary school in a northern city (hit by Hezbollah's rockets in the 2006 war); interviews and informal conversations with workshop facilitators and ICTP staff; listening and participating in lectures given at the center, and collecting texts produced at the unit, including scholarly articles, guidelines, booklets (prepared for workshop facilitators and participants) and the unit's internet site.

In addition, the first author worked for about a year (April 2011–July 2012) as a project coordinator at the Israel Trauma Coalition (ITC), an umbrella organization grouping together the leading NGOs in the trauma field in Israel.[9] This work included participation in developing, reaching out and implementing resilience-building projects and working with trauma experts and practitioners, attending their professional conferences and following their day-to-day policy decisions.

The ICTP is a pioneer organization in the trauma field in Israel, both as a research and as a therapeutic facility. It holds widespread ties to local and global centers of knowledge production in the field. While based in Jerusalem, its activities reach out to many other areas in the country that have been the target of terrorist attacks and rocket bombings. The resilience unit within the ICTP was established in the early 2000's, following the onset of the second Palestinian uprising against Israel's occupation of Palestinian lands (the Al-Aqsa Intifada), and the ensuing violence that swept the country. In particular, the Palestinian attacks have been mainly aimed at civilians, causing hundreds of casualties among Jewish citizens all over Israel. With the constant media coverage of these events, the issue of trauma became a widespread concern. Against this background, the unit founder and director, educational psychologist Dr. Naomi Baum, developed for Israeli schools a

[9] ICTP was one of ITC founding members, but left the organization in 2011.

comprehensive framework for dealing with psychological consequences of terrorism (Baum 2005). The intervention includes a school-wide screening program, training of school mental health professionals, treatment for children suffering from PTSD symptoms and a resilience workshop for teachers, which is a central ethnographic focus of this article.

In recent years, Baum's model has been implemented in hundreds of schools, especially in areas affected by war and terrorism. It has been revised and adapted for work with diverse social groups (kindergarten teachers, first responders and youth leaders), and it has been exported to disaster-stricken areas around the globe—like US in the wake of hurricane Katrina, Sri Lanka and Haiti. In the wake of Operation Protective Edge in Gaza (July–August 2014) and more recently in the face of the Palestinian so called third uprising (2015-present), which included many attacks aimed at the Israeli civilian population, resilience building initiatives have been further developed and expanded.[10]

Resilience Logics: Correcting Emotional Responses to Trauma

A growing number of social scientists and mental health professionals have been criticizing recently the use of PTSD in post-disaster interventions (Kienzler 2008). Stressing the pathologizing effects of PTSD, the critique has weakened its authority and has paved the way to the emergence of resilience-based interventions (Howell 2012). Thus, focusing on resilience and wellness differs from (and explicitly criticizes) earlier models of psycho-social interventions in disaster-affected areas around the globe, since they assumed universal vulnerability in the face of traumatic events and denied the resilience and agency of sufferers, turning them into frail and passive victims (McKinney 2007; Pupavac 2002; Scheper-Hughes 2008). Resilience is perceived, by contrast, as a positive and powerful human (and cultural) trait that can be triggered, enhanced, taught and fostered. Consequently, it is conceived as allowing for intervening in advance, during stressful conditions, in order to avoid the development of full-blown PTSD. Resilience focuses on protective factors, traits and behaviors that support health and adaptation in the face of adversity, rather than on illness and its diagnosis. Its ultimate goal is not to treat those suffering from the disorder, but to "immunize" individuals and the entire community against the effects of trauma (Friedman-Peleg and Goodman 2010).[11]

Israeli trauma experts were eager to embrace this new interest in the concept of resilience, as it provided a scientific basis and professional legitimation for the

[10] An example was the wide distribution (for parents and teachers in thousands of schools all around Israel) during Operation Protective Edge of a special resilience e-booklet titled "An emotional protected space: From stress reactions to functioning in emergency situations." The booklet was prepared by the Resilience Center ('Merkaz Hosen'; similar, yet competing with the NGOs covered in this article). It included detailed emotional guidance and diverse practices aimed at better functioning in the face of the stressful events.

[11] Young (2007) traces back this expansive logic to the emergence of a new form of trauma following 9/11 that he calls "PTSD of the virtual kind," for it includes "distant PTSD" related to indirect exposure to traumatic events (like watching TV images of a terrorist attack), and the expansion of diagnosis to individuals with only some symptoms of the disorder ("partial PTSD").

expansion of their jurisdiction in the violent days of the Al-Aqsa Intifada in the early 2000s (an expansion that has continued into the 2010s as well). Therapeutic interventions designed to enhance psychological preparedness for war and terrorism—modeled along the lines of Donald Meichenbaum's stress inoculation training (1985) and Suzanne Kobasa's concept of stress-hardiness (1979)—were already present in the Israeli psychological professional landscape since the 1980s. Still, their scope and extent were quite limited. Giving them a new impetus, both theoretical and practical, was due to a number of processes, both global and local. At the global level we should mention post 9/11 developments in the field of trauma such as the emergence of "PTSD of the virtual kind" (Young 2007). At the Jewish-Israeli local level, we can discern an ongoing process of routinization and civilianization of traumatic discourse in Israel, starting in the mid-70s following the Yom Kippur War (1973) and taking new impetus since the first Gulf War, with rockets from Iraq hitting civilian areas in Israel, and the Palestinian Intifadas. As Lomsky-Feder and Ben-Ari argue, "these developments are related […] to the changing nature of violent conflicts, in which terror attacks have blurred the conventional distinction between the 'front' and the 'rear'" (2007:118). The exposure to the Israeli-Palestinian armed conflict has thus turned every Israeli citizen into a potential victim, leading to an "equalization" with the Palestinians (ibid., p. 126). Moreover, in recent years trauma (and therapeutic intervention to counter it) has been expanded to the nation as a whole (Friedman-Peleg and Bilu 2011; Plotkin-Amrami and Brunner 2015) and to diverse social groups (Friedman-Peleg 2014; Friedman-Peleg and Goodman 2010; Plotkin-Amrami 2013).

The development of the ICTP model should be located then in the context of the growing critique of PTSD and the emergence of resilience. Hence, while criticizing psychiatric and psychoanalytic models, the ICTP model "focus[es] on assets and potential resources, not only on problems, risks and symptoms…" and it "stress[es] strategies of enhancement of assets, facilitation of protective processes, competence promotion rather than reductions of risks and stressors" (Baum 2005:491). Dr. Baum further explained during an interview:

> The emphasis is put on someone's strengths and capabilities instead of digging in what is missing, the half-empty glass. [I wanted] to focus on the half-full glass and see how can we broaden it, build it, move on with it. […] I am generally an optimistic person; I was never attracted to psychoanalytic, psychodynamic psychology. I am a very practical person, very focused, and it really attracted me, and I thought it would be worth to think how we take these topics, these concepts, into school life.

In a lecture to foreign mental health professionals, she argued that resilience is the ability "to bounce forward," a kind of "ordinary magic" that allows people to return to function and resume with their life after facing adversity. The idea, she said, is not to deny traumas and losses, but to be able to face them and change positively. Resilience is "normal," she argued, something that we all know but often overlook. Though "some people go off-track," she acknowledged, we are all actually programmed towards resilience, so that building it "brings us back to our source."

The intervention thus underscores sufferers' resilience and works actively to promote it. The workshops start from the widespread assumption that feeling stressed and traumatized are "normal reactions to abnormal situations." Therefore, and this is the first step in empowering individuals according to this new model, such responses should not be seen as signs of pathology, except for the most severe cases. This framing is especially compelling in the Israeli case, where "abnormal situations" abound due to the ongoing Arab–Israeli violent conflict, leading thus to life within what local trauma experts term "a routine of emergency." Instead of pathologizing traumatic reactions, the ICTP model aims at building resilience by teaching people how to cope with these repeated traumatic "abnormal situations." Accordingly, the workshops are directed to 'pre-clinical' clientele. As a workshop facilitator explained, "we are doing preventive mental medicine."

The resilience model does not deny the existence or the truth of trauma. In fact, trauma serves at times as a precondition for resilience. Thus, the facilitators assume that all participants have experienced some sort of trauma in their lives. The workshop's main goal, however, is not to process that trauma (as opposed to most therapeutic approaches to PTSD), but to acquire "tools" to deal with, and avoid, possible future traumas. Facilitators argued that the workshop can be beneficial for everyone, regardless of their mental health conditions and "exposure" level.

Resilience clinical ideology and its training represents thus a shift in the problematization of trauma, and yet it creates new ironies. Instead of focusing on the traumatic event and its psychological consequences (as detailed in the DSM's description of PTSD), it articulates the victims' emotional responses and especially their coping abilities. In this sense, resilience parts way with the dominant paradigm of trauma and its exclusive emphasis on the event. In doing so it shifts the focus back to individuals and their psychological constitution. Still, in no way is it a simple return to the psychogenic approach to trauma that characterized the suspicion paradigm (Fassin and Rechtman 2009). Unlike the pre-DSM psychoanalytic version of traumatic neurosis, the source of traumatic reactions, resilience-experts argue, is neither unconscious conflicts nor is it a faulty or weak personality. Instead, and here lies a central paradox, the problem is the subjects' (in)capacity to acknowledge, express and manage responses and emotions related to a traumatic event. This incapacity is not deemed pathological or abnormal, as the resilience model blurs the distinction between the normal and the pathological (except for severe cases of PTSD).[12] Hence, the project tries to hold together both the tremendous impact of a traumatic event and the possibility of eluding its burden.

[12] The blurring of the distinction between the normal and the pathological in the resilience paradigm has interesting moral underpinnings. Hence, the reluctance to label those who fail to cope with trauma as "abnormal" is probably due to the psy-professionals acknowledgment of the victims' moral superior status (cf. Fassin and Rechtman 2009). This is especially the case in Israel, where victims of war and terrorism enjoy a special moral status that clears them from any liability for their physical or mental injuries (Lomsky-Feder and Ben-Ari 2007). While emphasizing resilient responses, the resilience experts are usually careful not to blame the victim or harshly criticize individuals for not being resourceful enough.

The contradictions, or at the very least the tensions, entailed in the resilience project can be discerned in the following description of the workshop's rationale by Aviv, a workshop facilitator:

> This is an opportunity to put the topic on the agenda, that is to understand that we experience things and these experiences have an effect on us, and that it is legitimate that they have an effect, and that the fact that there is an effect doesn't mean that this is the end of the world.
> **Interviewer:** People don't just get that on their own?
> **Aviv:** It is not easy for them to get that on their own. It is easier to put that aside and go on, that is, not to understand how trauma affects me and how much it affects me. I usually don't talk about it. I usually don't give it the importance it deserves because it is so frightening, so I rather not pay attention to it. Many times this is so frightening that people become helpless.

Aviv's description of participants' 'emotional handicap' stems out of a deep criticism of the PTSD emphasis on the incapability of the traumatic subject, but it exposes the paradoxical nature of its replacement, the resilient subject. On the one hand, this subject experiences the traumatic event as "so frightening"—becoming helpless and showing denial and splitting characteristic of PTSD. On the other hand, it is assumed that there is still a part of the subject that can look at the event from without and calmly conclude that what he is feeling is "legitimate" and that "this is not the end of the world."

Self-examination Practices and the Objectification of Emotions

Let us look how this paradox is worked out pragmatically, in the resilience workshops. The construction of a spectating, stable and rational subject, capable of actively managing mental ails is processed in the workshops by using two inter-related practices: First, correctly identifying emotional responses to trauma and second, developing "resources" to manage them.

These 'technologies of the self' (Foucault 1988) allow participants to map their psychological interiority in order to rationally manage their self in times of stress. In trying to create a stable, transparent and spectating subject that is "fully knowable and recognizable to itself" (Weiner 2011:461), the resilience model explicates an autonomous and objective emotional realm that can and should be known and mastered by the subject. These practices rest on a reification of emotions, for they are understood as "discrete entities, somehow locked and trapped inside the self," and which "can be manipulated and changed by a work of appropriation" (Illouz 2008:142).

In order to be able to acknowledge our emotions, express them, and act upon them, we first need, argue the resilience experts, to know what we are feeling. This is not as simple and straightforward as it sounds, especially during traumatic events. In their view, the realm of emotions is uncertain and confusing. Subjects often have difficulties distinguishing between similar or related emotional states and identifying their possible causes. Hence, workshop participants are taught how to

correctly identify and in particular how to *name* their own and their students' or peers' feelings. Sylvia, a facilitator, explains:

> Sometimes it happens to me that I am in a bad mood and I don't know why, so I remember… I wake up in a bad mood and I remember 'ah, yes, that happened to me, therefore I feel this way.' And then I can understand if I am angry or I am sad or helpless… This is one of the specific goals of this training, to help them with the children in class to name feelings.

In Sylvia's account, there is a clear separation between a primordial and opaque emotional self and a spectating self that can rationally inquire into the mind's depths, discern between different emotional states and reconstruct what brought them about. Mapping emotions is accompanied by an interpretive framework that re-classifies complex and often ambiguous personal experiences into a set of pre-fixed emotional categories, while abstracting them from their immediate context. In this sense, it turns "what only appears to be random into discrete and controllable rationally organized entities" (Weiner 2011:464).

Various techniques are used to teach subjects to isolate emotions and map them. Facilitators present, for instance, a list of emotions and ask participants to choose one and mold it in clay. Clay is conceived as "elementary" and neutral material onto which participants can "project" their emotions. Participants examine their sculptures in small group discussions and then with the entire group and the facilitator. Another technique is presenting a number of colors and assigning a counter-intuitive emotion to each color (e.g., red representing joy instead of anger or love). The facilitator then asks participants to draw their individual "emotional map," and discuss it with their peers. The facilitator asks questions like: "Is this map representative of my usual feelings?", "When I feel a certain feeling, do I know how to classify it?", "Can I point at feelings that I experience more or less often?", "With which feelings is it easier for me to cope?"

Cheryl, a facilitator, illustrates the application of the clay molding technique in a kindergarten in Sderot, a town in Southern Israel hit by Hammas rockets. A girl sculpted a little marble to represent the emotion of "fear." She said it is a shrapnel that came in through the window above her brother's head. Cheryl explained:

> This was a big story: The parents were not at home when there was a 'red color' alarm,[13] so the children, this is a child-blessed family, took all the children to the security room, and they realized that they didn't bring the baby, and a Qassam shrapnel came in through the window above the baby's bed. Nothing happened to him. But the fact that this girl could make this ball at the kindergarten and say 'this is the ball that almost hit my brother, this is my fear'…

In this familial dramatic scene, the girl's emotional reaction is not merely repeated but instead it is objectified and transformed into a "cold cognition"—that can thus be observed and manipulated at will (Illouz 2008). As Cheryl implies, the

[13] Warning alarm activated by the Home Front Command defense system before a missile hits the ground.

objectification of the girl's emotional experience gives her mastery over it and helps her cope with its traumatic effects.

Developing Coping Resources

The paradoxical presencing and rejecting (or denying of) trauma through these techniques is rationalized by explaining that the ultimate goal is to become better prepared to monitor one's emotions in times of stress. Echoing the self-management paradigm (Weiner 2011), these practices serve as a management tool that provides the spectating self a situation report about 'emotional information' in real time. Presumably, it enables the government of the affected part of the subject by deliberate activation of emotion management strategies.

Hence, after learning to "get in touch with their emotions," workshop participants proceed to learning coping tools in a process called "resourcing." Resourcing consists of translating context-dependent, spontaneous and often unreflective ordinary behaviors and emotional responses into deliberate "coping tools." The goal is to expand the participants' "toolkit" for coping with traumatic events and providing help to others in the scene (like students and fellow first-responders). Drawing upon Lahad's (1997)[14] widely-used multi-dimensional model of "the human code of survival," resources are conceptualized as assets that the self can nurture during the controlled, relatively calm, workshop experience—and then mobilize in times of crisis. Like in other aspects of the intervention, the resilience experts make efforts to simplify matters and make their techniques user friendly and easy to memorize. Thus, it is taught that each individual's "coping style" comprises an idiosyncratic combination of six (presumably) universal "coping channels" (abbreviated as BASIC-PH): *Belief* (relying on religious, political or personal values); *Affect* (expressing emotions); *Social* (seeking support in friendships and social networks); *Imagination* (using fantasy and imagining creative solutions); *Cognition* (gathering information and problem solving); and *Physiology* (engaging in physical activities such as relaxation or exercising). Facilitators' task is to help subjects to identify and reinforce their preferred modes of coping along with developing additional strategies that are currently out of their usual comfort zone.

"Resourcing" is carried out in workshops by eliciting narratives about participants' past responses to stressful events and learning to map them in terms of the BASIC-PH typology. These exercises use projective techniques that express the ambiguous subject, encompassing both "trauma" and "strength." When using, for example, "therapeutic cards"[15] to elicit participants' narratives, each participant is asked to choose both a card related to "a difficulty" and a card that represents "a source of strength." Participants share their choices with a partner and then with the

[14] One of the pioneers in the Israeli emergency psychology field.

[15] These are cards including abstract drawings which are widely-used by psy-professionals in Israel for projective exercises and for eliciting talk about different issues. In contrast to Rorschach or TAT, therapeutic cards are non-standardized tools and they can be used as therapists find suit. For some examples, refer to the following websites: http://www.en.itzikcards.co.il/site/index.asp?depart_id=113508&lat=en, http://nordcards.com/index_en.php?category_id=166, both last accessed July 23, 2016.

group. The facilitator writes the responses on the board and classifies them according to BASIC-PH. Esther, a facilitator, explains the rationale:

> It conceptualizes the process that they sometimes go through or experience. I think that this conceptualization of familiar processes is important. I'll give you an example: when we work on resources and suddenly we include things like cooking or a phone call to a friend and suddenly this simple and practical action of talking with a friend over the phone is conceptualized as a resource that can be of help, this is important. This conceptualization bestows meaning on action. […] Conceptualizing feelings, conceptualizing the situation, naming it, giving it a title, conceptualizing the action that I do anyway and classifying it into a category. […] This conceptualization has therapeutic value. […] The conceptualization gives us mastery, sort of a feeling that I control the situation and I understand what happens.

The key to "resourcing" is the "conceptualization" or re-framing of ordinary behaviors and emotional responses that come "naturally," like cooking, as "coping resources" that can be willfully mobilized by the subject in the face of trauma. It is the conceptualization, not the response itself that gives us mastery over traumas.

This cognitive approach exposes a deep paradox in the resilience model. On the one hand, "resourcing" aims at building resilience by using the inherent "anti-bodies" of subjects. According to the physiology of stress responses on which the model is based, these anti-bodies are enlisted by the organism's emergency response to an outside threat (the 'fight or flight response'). This response is not mediated by the subject's conscious will, but is automatically triggered by the sympathetic nervous system as part of a process of physiological mobilization that aims at adjusting the organism to the external challenge (Young 1995:21–24; 2007:26). On the other hand, in the resilience project, an emergency response has therapeutic value *only insofar as it is conceptualized as such*. In order for the ordinary activity of cooking to serve as a protective factor in times of stress, it must first be reflexively construed and classified as a "coping resource" by a pre-traumatic subject with the aid of psychological expertise. Only then can subjects deliberately and rationally choose to mobilize this resource when faced with a possibly-traumatic event.

Questioning "Coping Resources"

The ambiguities of the resilient subject—who is supposed to gain mastery over traumas by reflexively developing coping responses—become apparent within the lived experience of workshop participants. Many of them readily embrace the idea of coping resources and enthusiastically engage in "resourcing," at least during the workshop. Yet, we could also discern diverse instances of a breakdown in the neat rational, managerial subject. Questioning this new evolving subjectivity is often expressed in an implicit manner, like in the ethnographic moment we opened up with. At times, however, they turn into a more explicit and elaborated critique. Earlier in that workshop session, Rosa, the facilitator, asked teachers to tell a story

about how they coped with a difficult situation. In what turned out to be one of the most charged moments of the workshop, Dorit shared how she responded to the tragic events that struck her family. When her sister-in-law was killed in a terrorist attack, she functioned "like a robot," arranging the funeral and the Shiv'a,[16] then falling apart when her family no longer needed her help. When her nephew (from a different brother) was killed during his military service, she broke down and could hardly function. Rosa tried to classify Dorit's reactions:

> You also said something. 'I didn't come to work, but at some point I realized that it doesn't help and I came to work.' Coming to work means seeing your students, seeing your friends at work…
> **Dorit:** I didn't come to see my students. Neither to see my friends. I came because I have to come to work in the morning. That's all. I didn't come to see anyone. You don't see anyone.
> **Rosa:** But nevertheless…
> **Dorit:** You come because this is part of your day and of your routine and you must go on.
> **Rosa:** And it doesn't help?
> **Dorit:** I don't know if it helps.

The facilitator offers that Dorit's emotional reaction should be reframed as a deliberate coping response, presumably of the *Social* type in terms of the BASIC-PH model, but Dorit rejects this interpretation outright. For her, going to work was not a premeditated coping response, but a return to routine, perhaps "in the context of making the everyday inhabitable" (Das 2007:216).[17] Revital, the school counselor and a psy-professional herself, steps up to help Rosa:

> Every person has a coping style that suit him the most. Maybe for Dorit other styles suit her better than this style and it's ok, everyone has a style. The most important thing is that she has a style, because every style is good, every style is right. […] Why are we bringing this up? […] Because many times if we know there is a variety of coping styles, if the style that I know so well didn't work for me, I can look for a different style.
> **Yael [teacher]:** The question is when you are, heaven forbid, in the middle of a situation, tragedies… 'Now I will use the behavioral, social and emotional style?'
> **Orna [teacher]:** Good question.
> **Revital:** That's what the simulations are for.
> **Yael:** These are things that come up during the situation and I start to acknowledge them and actually what my heart says is what finally happens. Or that I actually have to say to myself: 'wait, I have the B and the A and the S. So what do I do now: B, A or S?'

[16] The seven days of mourning after the death of a family member.

[17] In writings about the violent national conflict in India, Das (2007) argues that life is recovered through a "descent into the ordinary" (p. 7). In her view, the "ordinary" functions as a space in which victims of violence can re-become subjects.

Dorit: You know, I am happy that you brought this up, because it is right. You can't just come and say 'I will choose.' You can't choose these emotions… they simply jump up.
Rachel [teacher]: (sarcastically) 'I have a list, let's pick…'
Revital: What is the goal of this workshop? Why do we have it? The goal is to identify things during calm times, so that if, heaven forbid, there is a stressful situation we will already know and will be ready. What happens in times of stress? In times of stress you are right, we are confused. I won't just stop for a moment and think what suits me and what not. But if during calm times we learn what coping styles are available to us… For example I adopted guided imagery for myself. It is a coping style. I wouldn't have used it in times of stress, but then with all this resilience project that I do with the children here at school, I learned to use guided imagery. We practiced it a couple of times and I realized that these exercises fulfil my needs when I feel stressed. They help me, they provide me a tool. So during calm times, when you feel safe, then you learn. During stressful situations maybe you forget what you learned, but if we remember for example that if I do something in that moment it will help me, so maybe I will work on myself. If I found that guided imagery helps me, I will do it. That is, everyone finds something in addition to what he is used to.
Rosa: It is not either/or.
Rachel: No, the question is… Again, Dorit told us in retrospect how she acted and how she responded. Now you can say 'I acted like A, B or C.' But what builds me? Is it this talk or did my personality build me about this choice?

A controversy develops then between the lay persons and the professionals over the clinical ideology of resilience, and over the techniques used to facilitate it. Is it possible to become a self-managing subject by using the suggested emotion pedagogies? Revital upholds this possibility by sharing with the group how she adopted guided imagery as a coping tool to be deliberately deployed in times of stress. The teachers, by contrast, find it difficult to distance themselves from the traumatic event and to look at it from without, as if they were not part of it. They ironically ridicule the over-rationality of the model, and question the possibility of choosing between emotions and different courses of action in the midst of traumatic events. They further doubt that emotional reactions to trauma can be willfully controlled, even after going through a proper training. In their experiences, when faced with a traumatic event emotions simply and automatically "jump up" (Hebrew '*koftzim*'). They spontaneously come "from the heart," without the mediation of conscious thought or volition. The BASIC-PH model can, at its best, only help us classify our responses *retrospectively*.

The teachers' critique of the resilience intervention challenges then the rationalization of emotional responses to trauma. It points to the undergird ambiguities entailed in separating event from emotion, and specifically the difficulty of isolating and reifying emotional reactions, abstracting them from their particular context, and presenting them as mere options to choose from. Their doubting undermines the construction of a transparent, self-modulating rational subject that is capable of maneuvering emotions in traumatic situations.

The teachers' experience of trauma express the tension between the renewed interest in individuals' psychological responses and the enormity of an abnormal event. They thus express subjects' elusive forms of agency, marked by fragmentation, uncertainty and spontaneity in the face of trauma. The traumatized self, they offer, is unpredictable, never fully knowable or controllable. For them, becoming an actively resilient subject is foreclosed by the inevitable immersion of the self in the traumatic scene.

Concluding Notes: Ambiguities of the Resilient Subject

The resilience project complicates the anthropological critique of the deployment of interventions based on PTSD in disaster situations around the globe. It presents a form of psychologizing—along with its new ambiguities—that defies established dichotomies between Western medical knowledge and local idioms of distress. A new set of problems that speak in turn to older deliberations around trauma are thus emerging. To begin with, the ambitious resilience project is aimed at subjects' transformation: both selfhood and emotions are supposed to be reconfigured. The subject, as an individual, is encouraged to become a center of control and agency and its 'interior' realm is supposed to become a space of discrete 'emotions' and 'resources' that are to be discovered and mastered with the help of psy-experts. As we demonstrated, while allowing for the expansion of new professional interventions, this clinical ideology and the accompanied resilience-building practices encompass deep paradoxes and contradictions. On the one hand, the model recognizes trauma as an event outside the range of ordinary human experience and thus as overwhelming the psyche's capacity to respond and even to consciously register and acknowledge it. Still, on the other hand the new resilience project presupposes a spectating self that remains unaffected by the traumatic event and can willfully and rationally deploy coping mechanisms in real time. Furthermore, the attempt to separate between a sovereign rational subject and a post-traumatic subject is deeply troubled in the face of the experience of trauma and social suffering.

The efforts to construct a resilient subject invites then a renewed interest in the elusive interface of events and subjective experience: To what extent do traumas mark subjects? And, to what extent these can be assimilated and processed by a knowing subject? Negotiating the resilient subject both reproduces and challenges, we thus argue, the expanding bio-medical and neoliberal self-management paradigm in mental health (cf. Weiner 2011). The resilience-building project speaks then to problems of locating a subjective anchor capable of managing experience by means of rational techniques that are not contaminated by trauma and disorder.[18]

[18] This project also raises questions about subject formation and the desirability of being able to inhabit the coherent resilient self. For instance, a Lacanian psychoanalyst may find it actually mentally healthy not to be able to inhabit the ideal resilient self, and to "continue" living as a divided subject; the wound should be considered a crucial element that creates paths towards subject formation. The injunction to "be resilient" (before a trauma occurs, or in a country where everybody is potentially traumatized) deserves to be problematized and confronted then with a Lacanian model that insists on contradictions, discontinuities or breaks within the subjects, and with recent questions raised within the sociology of autonomy (see Ehrenberg 2010; 2014). We thank the reviewer of our manuscript for bringing up this point.

No less important, the resilience model reconstitutes unresolved tensions between mimetic and anti-mimetic tendencies that pervade the concept of psychological trauma since its early days in the theories of Freud, Janet and others and in its more recent reincarnations in American and global psychiatry (Leys 2000).

The paradoxes entailed in the resilient subject should also be articulated within their broader local and national contexts. Returning then to our opening: How should we interpret Dorit's resistance? She provides a hint, we suggest, while referring to the ubiquity of bereavement in Israel. "This is not a normal country, where people die when they get old," she says, "this is a country where you hear all the time bereavement, bereavement, bereavement, but it is different when you are a part of it." Perhaps for Dorit—who resides in Israel's geographical and social periphery—adhering to the 'national trauma' and joining the 'family of bereavement' allows for asserting her belonging and contribution to the State and to the Jewish collective. Embracing resilience is thus filled with ambivalence, for while it expresses the heroic Zionist triumphant subject, it also overshadows at times a preferred and much admired subject position of the victim (Friedman-Peleg and Goodman 2010). Resilience leaves behind bereavement and loss, which are 'the norm' in Israel. Perhaps for these teachers from Israel's neglected periphery, being traumatized may express a form of belonging—and participating in the collective narrative of national sacrifice—that they are not so easily willing to give up.

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Conflict of interest Authors Ariel Yankellevich and Yehuda C. Goodman declares that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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References

Baum, Naomi L
2005 Building Resilience: A School-Based Intervention for Children Exposed to Ongoing Trauma and Stress. Journal of Aggression Maltreatment and Trauma 10(1–2): 487–498.

Breslau, Joshua
2004 Introduction: Cultures of Trauma: Anthropological Views of Posttraumatic Stress Disorder in International Health. Culture, Medicine, and Psychiatry 28(2): 113–126.

Brunner, José
2002 Identifications, Suspicions, and the History of Traumatic Disorders. Harvard Review of Psychiatry 10(3): 179–184.

Das, Veena
2007 Life and Words: Violence and the Descent into the Ordinary. Berkeley: University of California Press.
Dwyer, Leslie, and Degung Santikarma
2007 Post-traumatic Politics: Violence, Memory, and Biomedical Discourse in Bali. *In* Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives. Laurence J Kirmayer, Robert Lemelson, and Mark Barad, eds., pp. 403–432. Cambridge: Cambridge University Press.
Ehrenberg, Alain
2010 The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age. Montreal: McGill-Queen's Press.
2014 Individualisms and Their Discontents: The American Self versus the French Institution. Philosophy, Psychiatry, and Psychology 21(4): 311–323.
Fassin, Didier, and Richard Rechtman
2009 The Empire of Trauma: An Inquiry into the Condition of Victimhood. Princeton: Princeton University Press.
Foucault, Michel
1988 Technologies of the Self. *In* Technologies of the Self: A Seminar with Michel Foucault. Luther H Martin, Huck Gutman, and Patrick H Hutton, eds., pp. 16–49. Amherst: The University of Massachusetts Press.
Friedman-Peleg, Keren
2014 Between Jewish Settlers and Palestinian Citizens of Israel: Negotiating Ethno-National Power Relations through the Discourse of PTSD. Culture, Medicine, and Psychiatry 38(4): 623–641.
Friedman-Peleg, Keren, and Yehuda C Goodman
2010 From Posttrauma Intervention to Immunization of the Social Body: Pragmatics and Politics of a Resilience Program in Israel's Periphery. Culture, Medicine, and Psychiatry 34(3): 421–442.
Friedman-Peleg, Keren, and Yoram Bilu
2011 From PTSD to "National Trauma": The Case of the Israel Trauma Center for Victims of Terror and War. Transcultural Psychiatry 48(4): 416–436.
Hacking, Ian
1998 Rewriting the Soul: Multiple Personality and the Sciences of Memory. Princeton: Princeton University Press.
Howell, Alison
2012 The Demise of PTSD from Governing Through Trauma to Governing Resilience. Alternatives 37(3): 214–226.
Illouz, Eva
2008 Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-help. Berkeley: University of California Press.
James, Erica Caple
2004 The Political Economy of 'trauma' in Haiti in the Democratic Era of Insecurity. Culture, Medicine, and Psychiatry 28(2): 127–149.
Kienzler, Hanna
2008 Debating War-Trauma and Post-traumatic Stress Disorder (PTSD) in an Interdisciplinary Arena. Social Science and Medicine 67(2): 218–227.
Kleinman, Arthur, Veena Das, and Margaret Lock
1997 Social Suffering. Berkeley: University of California Press.
Kleinman, Arthur, and Robert Desjarlais
1995 Violence, Culture, and the Politics of Trauma. *In* Writing at the Margin: Discourse Between Anthropology and Medicine. A Kleinman, ed., pp. 173–189. Berkeley, CA: University of California Press.
Kleinman, Arthur, and Joan Kleinman
1997 The Appeal of Experience; the Dismay of Images: Cultural Appropriations of Suffering in Our Times. *In* Social Suffering. Arthur Kleinman, Veena Das, and Margaret Lock, eds., pp. 1–23. Berkeley, CA: University of California Press.
Kobasa, Suzanne C
1979 Stressful Life Events, Personality, and Health: An Inquiry into Hardiness. Journal of Personality and Social Psychology 37(1): 1–11.

Lahad, Mooli
1997 BASIC Ph: The Story of Coping Resources. *In* Community Stress Prevention. Mooli Lahad and Alan Cohen, eds., pp. 117–145. Kiryat Shmona: The Community Stress Prevention Center.
Leys, Ruth
2000 Trauma: A Genealogy. Chicago: University of Chicago Press.
Lomsky-Feder, Edna, and Eyal Ben-Ari
2007 Trauma, Therapy and Responsibility: Psychology and War in Contemporary Israel. *In* The Practice of War: Production, Reproduction and Communication of Armed Violence. Aparna Rao, Michael Bolig, and Monica Bock, eds., pp. 111–131. New York: Berghahn Books.
McKinney, Kelly
2007 "Breaking the Conspiracy of Silence": Testimony, Traumatic Memory, and Psychotherapy with Survivors of Political Violence. Ethos 35(3): 265–299.
Meichenbaum, Donald
1985 Stress Inoculation Training. New York: Pergamon Press.
Plotkin-Amrami, Galia, and José Brunner
2015 Making Up 'national Trauma' in Israel: From Collective Identity to Collective Vulnerability. Social Studies of Science 45(4): 525–545.
Plotkin-Amrami, Galia
2013 Between National Ideology and Western Therapy: On the Emergence of a New "Culture of Trauma" Following the 2005 Forced Evacuation of Jewish Israeli Settlers. Transcultural Psychiatry 50(1): 47–67.
Pupavac, Vanessa
2002 Pathologizing Populations and Colonizing Minds: International Psychosocial Programs in Kosovo. Alternatives 27: 489–511.
Rose, Nikolas
1996 Inventing our Selves: Psychology, Power, and Personhood. Cambridge: Cambridge University Press.
Scheper-Hughes, Nancy
2008 A Talent for Life: Reflections on Human Vulnerability and Resilience. Ethnos 73(1): 25–56.
Weiner, Talia
2011 The (Un)Managed Self: Paradoxical Forms of Agency in Self-management of Bipolar Disorder. Culture, Medicine, and Psychiatry 35(4): 448–483.
Young, Allan
1995 The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder. Princeton: Princeton University Press.
2007 Posttraumatic Stress Disorder of the Virtual Kind: Trauma and Resilience in Post-9/11 America. *In* Trauma and Memory: Reading, Healing, and Making Law. Austin Sarat, Nadav Davidovitch, and Michal Alberstein, eds., pp. 21–48. Palo Alto: Stanford University Press.