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From Victim to Victor: The Development of the BASIC PH Model of Coping and Resiliency

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This article summarizes my personal journey in the field of trauma starting in 1975 and tries to trace its "origin" in my early life experiences. It mostly focuses on my field experience as a pioneer professional (academician and practitioner) in a rural area of Israel in the late 70s and early 80s. In this personal and professional encounter with the harsh reality of a community living under constant threat of shelling and of terrorists' infiltration, I realized there was a huge gap between my clinical training and the real life of these people who were forced to cope with this situation for years. This has led to one of the first attempts worldwide to research and develop an integrative model of coping and resiliency. The results yielded a new model: the BASIC Ph Model. This model builds on an understanding of the community impacted and the ability of the inhabitants to withstand disasters and crisis and led to the development of one of the first comprehensive resiliency programs. Among other things, the program using the BASIC Ph Model ensured that there would be a professional role of Emergency Behavioral Officer(s) with the job of enhancing trauma resilience city-wide. A diagram and table are presented and discussed to help to explain the elements and approaches covered in the BASIC Ph Model. The latter section of the article discusses the cross-sectional studies of the model and recent developments in its many uses.

Keywords: PTSD, resilience, BASIC Ph, community, education

I was born in 1953 in Haifa to a family of three. My father was, on the one hand, an author, autodidact scholar, the most respected expert on Jewish theater and drama, with a private collection of 4,000 manuscripts of drama plays, and on the other hand, a lieutenant colonel in the Israeli navy. My mother was born in Jerusalem to her parents who left Berlin in the early 1920s to go and live in Jerusalem for pure Zionism. Her father left a judge's position and her mother was from a family of bankers; both left an affluent life but died very young, leaving her a young orphan.

We lived in a very modest rented flat from our Arab landlord in the German colony in Haifa, which was a small neighborhood with an outstanding mixture of Israel Defense Forces (IDF) high officers, Sabras, Christian Arabs, newcomers from Morocco, Rumania, Bulgaria, Poland (Holocaust survivors), and Greek and Turkish families. The houses' doors were always open, and we grew up in a delicate balance of diverse mentalities. Whenever a major conflict aroused, my mother, the only Israeli-born adult, with extreme sensitivity to human suffering and a particular way to build bridges to the ones in need, was running to the scene (sometimes between raveling knives) to calm the parties and instill peace. Thus, she was known as "Dag Hammarskjöld," the then United Nations (UN) secretary general. I believe that a lot of what influenced my personality, beliefs, and attitudes was planted then.

I grew up in other places in Haifa and left the city for the army service where I served in the air force as a noncommissioned officer (NCO) in the Israeli Air Force Command headquarters. Being less than 20 years old, I was involved in the Yom Kippur war side by side with the air force commander, the late Gen. Benny Peled, and spent most of the harsh hours and days of the war beside him as one of his command staff. Watching the way he led the air force staff and commanders throughout unprecedented losses of planes and pilots, many of them his friends and colleagues falling in combat almost "in front" of our eyes, was a significant experience. His ability to control his emotions, instill hope in a despairing command post, and cleverly look for unique solutions while keeping his appearance intact, always clean and tidy, was an amazing image and a lesson on how to manage the crisis.

Personally, I lost friends in the war, and close friends were captured and held in Syria. I was intensively involved in supporting their families, spending all my "spare time" and weekends with them, going with them to the Red Cross prisoners of war identifying center. Indeed, this was another significant experience in coping and resiliency even before I came to know these concepts professionally.

I volunteered for an extra year in the military to help in the postwar rehabilitation efforts, left the army after those years, and started my studies in psychology, first and second degree. In 1975, I joined the first project working with bereaved families launched by the Israeli Ministry of Defense (MoD) and lead by Dr. Nira Kfir. I was exposed to families and their different ways of grieving. My supervisor at that time was Prof. Jacob Frenkel, a student of Carl Rogers, and this humanistic existentialist approach was very influential on who I am as a mental health professional. Throughout my studies, I worked in the most neglected areas in Tel Aviv and Bet Shemesh neighborhoods.

In 1979, I left Tel Aviv with my late wife for the Kiryat Shmona, a Northern town that was infiltrated by a terrorist in 1974 and was under constant shelling of rockets since the 1970s. We

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came for a year and stayed 20 years. We built a home and raised four amazing children.

Coming to the North, I encountered a phenomenon I did not hear nor learn about. I was expecting (as many years later I heard in meetings with professionals during my visits to New York following 9–11) that the vast majority of the population that was under attacks, with no alert nor shelters, would suffer from severe symptoms. To my amazement, I realized that they are managing normal life and that the clients we had in the mental health center were very similar to the ones I met in the heart of Israel. Sometimes I say that the only difference is that in central Israel there were a variety of reasons for the suffering, and we needed the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), whereas in Kiryat Shmona there was a single etiology: "Katusha," the Russian-made rockets that were launched on the town quite often. Of course, there were people affected by the situation with what was known as stress neurosis or traumatic war neurosis.

So my colleagues and I at the combined mental health and school psychology services in the town started to question what happened. Why do we have the same type of complaints, the almost same size of clients' loads, where such life-threatening events happen constantly? There was virtually no literature to describe what we saw. In the late 70s, there was so much on pathology and very little on coping. So we started to study the local population. The first study (Lahad & Abraham, 1983) was with 400 children and some 300 adults asking them an open-ended question: "What helps you in such conditions"? Moreover, we administered many tests (including the State and Trait Anxiety Inventory [STAI], client drawings and symptoms, and sentence completion tests).[1] The results were thousands of responses that had to be categorized. To this day, I cannot believe how "courageous" we were, without computers, Statistical Package for the Social Sciences (SPSS), and Natural Language Programs, to look into these responses.

Dr. Ofra Ayalon, a pioneering psychologist who was doing much work after the Yom Kippur war (1973) with schools and children was an inspiration and amazing help because she had already designed an intervention program for children called "Rescue." Particularly useful were her conceptual maps or categories that helped explain and apply her work.

She was very generous and offered to help me design the first-ever prevention intervention program to work with school teachers and children who were directly exposed to ongoing attacks. This was the beginning of a lifelong friendship, and we coauthored three foundation books for the Israeli mental health and education system written in Hebrew on how to cope with stress and crisis. The books, hereafter referred to as the "life books," focus on coping with traumatic events that were human-caused, natural disasters, and industrial accidents, from individuals, families, groups, and organizational.

The three "life" books are: *Life on the edge* (Ayalon & Lahad, 1990), *On life and death* (Lahad & Ayalon, 1995; still the only death education book in Israel), and *Your life ahead* (suicide prevention; Ayalon & Lahad, 1996). These textbooks and intervention guides are widely used by professionals and semiprofessionals even 20 years after their publication. Parts of these books were translated into other languages.

In the summer of 1980, following a massive 10-day rocket attack on the town of Kiryat Shmona, with thousands fleeing away or staying in shelters, the Israeli Ministry of Education asked the school psychology service to open the first Stress Center for the whole of Israel's Northern Education system. Because I had already developed my program, I was asked to manage it. The Ministry of Education asked us to focus on four areas: studying how the "normal" population copes with stress (with a focus on children and education system), developing psychoeducation prevention/intervention/rehabilitation models tools and measures and compiling all knowledge in the form of a library, and creating the first ever school crisis intervention teams to be on site within 4 hr of any crisis. Within 10 years of its establishment, this project became an independent nongovernment organization (NGO), with its professional steering committee known as the Community Stress Prevention Center, celebrating to date its four decades of service to professionals and the community as a whole.

Historical Overview of Stress and Coping: "The Survival Game"

The question of survival of the human race as a philosophical, psychological, and physical query has long routes. The field of psychology was not different in asking why the most vulnerable mammal with the longest maturation process survived from times ago. Historically, most of the foundation theories in psychology looked at the development of the human child and described their construct or theory on "How do we make it?" Some of these attempts tried to present an exclusive explanation, while others tried to highlight one aspect of previous theories. One can construe from these attempts six fundamental elements in explaining human survival (Lahad, 1992). B for beliefs, A for affect or emotions, S for social, I for imagination, C for cognition, and Ph for physiology.

Freud (1933) stressed the affective world, both inner (i.e., unconscious) and overt (projection and transference), and it is Freud who stated that early emotional experiences, conflicts, and fixations determine the way a person meets the world. Often, this unconscious part overrides the transactions in reality.

His colleagues, Erikson (1963) and Adler, (1956), albeit from different angles, highlighted the role of society and the social setting in the way a person meets the world—Adler in his theory of inferiority and the drive for power and Erikson in his eight stages of development. Jung and Chodorow (1997), who was originally a student of Freud, emphasized the symbolic and archetypal element, imagination, "the culture heritage," and the fantastic inner and outer world. Jung also mentioned intuition as one of his personality types.

Other psychological theories have dismissed the whole idea of psyche and emotion and have attempted to describe the human behavior regarding stimulus and response. This has been called behaviorism, but we suggest that they should be called physiologist because their theory suggests instinctual chains of reactions resulting in behavior (Pavlov, 1927). Before long, the cognitive school found its theory about the way a person meets the world and they phrased it "It's all in the mind," or cognitive processes with errors of thought or perception (Beck, Rush, Shaw, & Emery, 1979).

[1] STAI-State and Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983).

Table 1
The Psycholinguistic Model of BASIC Ph

B	A	S	I	C	PH
Belief	*Affect*	*Social*	*Imagination*	*Cognition*	*Physical*
Self, Ideology	Emotions	Role, others, organization	Intuition, humor	Reality, knowledge	Action, practical
Frankl	Freud	Erikson	Jung	Lazarus	Pavlov
Maslow	Rogers Adler		De Bono	Ellis	Watson
Attitudes	Listening skills	Social role	Creativity	Information	Activities
Beliefs	Emotions	Structure	Play	Order of preference	Games
Life-span	Ventilation	Skills	Psychodrama	Problem solving	Exercise
Value	Acceptance	Assertiveness	"As-if"	Self-navigation	Relaxation
Clarification	Expression	Group	Symbols	Self-talk	Eating
Meaning		Role play	Guided imagery/fantasy		Work

Last but not least, we have the belief and meaning stream, presented by Maslow (1954) and Rogers (1961). Moreover, Frankl (1959) developed psychological theory and psychotherapeutic approaches. Logotherapy by Victor Frankl (1959) and client-centered therapy by Carl Rogers (1951, 1961) was based on his existential theory and practice, and to an extent Pearls, Hefferline, and Goodman (1951) with Gestalt therapy.

We believe that these exclusive attempts to describe human psychic life have many disadvantages and that human psyche is more complex than the theoretical attempts to describe it in one or two dimensions. Our study of coping and resilience in both ongoing and short-term emergencies lead us to identify six dimensions that in our experience underlie the coping style of the client: belief and values, affect (emotional), social, imaginative, cognitive, and physiological. We have named it BASIC-Ph.[2] It is the integrative multifaceted approach that suggests a combination of these elements in the unique coping style of each person (see Table 1).

Obviously, people react in more than one of these modes, and everyone has the potential to cope in all six modes. Still, each person develops his special configuration. Most of us, at different times, have a preferred mode or modes of coping and will use this extensively. From hundreds of observations and interviews with people under stress summarized in Lahad, Shacham, and Ayalon (2013) and Lahad, Leykin, Rozenblat, and Fajerman (2014), it is apparent that each has a special coping mechanism or resources that characterizes his or her special way "to meet the world." But it is important to note that most people have more than just one mode, and many have up to three or four (Lahad, 1997).

Across research and practice, there has been considerable debate over the definition and operationalization of resilience (Luthar, Cicchetti, & Becker, 2000). Is resilience best categorized as a process, an individual trait, a dynamic developmental process, an outcome, or all of the above? Where does one draw the line at successful and resilient adaptation versus nonresilient responses?

Resilient personalities are characterized by traits that reflect a strong, well- differentiated, and integrated sense of self (self-structure) as well as traits that promote strong reciprocal interpersonal relationships with others (Garmezy, 1991; Greeff & Ritman, 2005; Shiner, 2000).

Zautra et al., (2008) suggest, for example, that "Whereas resilience 'recovery' focuses on aspects of healing of wounds, 'sustainability' calls attention to outcomes relevant to preserving valuable engagements in life's tasks at work, play, and social relations" (p. 44).

We define resilience as self-stabilizing and overall healthy patterns of development, which lead neither to a life of disordered behavior (drugs, delinquency, etc.) nor to manifest mental or psychosomatic syndromes. It is noteworthy that temporary oscillations of individual behavior on the health–disorder spectrum under the impact of an acute stressor are implied, but in the medium and long-term, a remission of symptoms should occur. The individual degree of resilience is understood as being relative in so far as quantitative and qualitative variations cannot be ruled out (Lösel & Köferl, 1989).

As early as 1992, we were referring to resiliency as the ability of the individual to withstand and recover from adversities and crisis by oneself or with the help of others. Our references were as follows: (a) observation and direct questioning of people who lived under constant threat; What is helping you to make it day by day?; and (b) a psycholinguistic approach asserting that the way someone describes his experience represents inner structure of making sense by which that person perceives/absorbs and transmit communication inside and outside.

The Integrative Model of Coping and Resiliency BASIC Ph

In retrospect, research into coping with stress produced decisive contributions. Coping was defined by Folkman and Lazarus as a process of constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. They defined two forms of coping: problem-focused coping and emotion-focused coping (Folkman & Lazarus, 1988). The primary appraisal category, "challenge" in their stress model, is particularly worthy of consideration. Two significant trends are important for stimulating resilience research: (a) the transformation of the trend toward negative pathogenic effects of a stressful life event through

[2] Only when I submitted my first PhD in 1984 in the United Kingdom I was introduced to Multimodal Therapy (MMT) of Arnold Lazarus and his BASIC ID (Lazarus, 1981). My mentor even suggested that we call it a different name, but because my thesis was already printed, we looked into the difference between the two models, and the most apparent was that most of the modalities were defined in negative terms (unlike my work that be seen as "predecessor" of positive psychology), and the acronyms are not the same: B = behavior, A = affect, S = sensation, I = imagery, C = cognition, I = interpersonal relationships, D = drugs.

coping; and (b) the reappraisal processes into a new homeostasis promoting psychological and physical health.

Since the mid-80s, most stress models have taken into account not only the psychopathological syndromes but also variables in psychological health and well-being (e.g., Lazarus & Folkman, 1984; Moos, 1984). However, it is only in this decade that empirical psychology has begun to conceptualize resilience applying models that are based explicitly on the idea of healthy or adaptive development in the face of stressful influences, rather than by using derivatives of stress–disturbance models.

As mentioned previously, it was in the early 80s (Lahad & Cohen, 1998), that we identified different coping styles and coping mechanisms used by various people under stress. The following will be a general description of each of the modes. Despite its variety, our studies showed time and again that the dominant coping modes are rather stable over time (Leykin, 2013).

There are those whose preferred mode of coping is cognitive mode. They are the C-cognitive oriented copers. The cognitive strategies include information gathering, problem solving, self-navigation, internal conversation, or lists of activities or preference. Another type will demonstrate an emotional or A-"affective" coping mode and will use expressions of emotion: crying, laughter, or talking with someone about their experiences; or will use nonverbal methods such as drawing, reading, or writing to express themselves.

A third type will opt for S-a social mode of coping. They receive support from belonging to a group, taking a role, and being part of an organization.

A fourth will use their I-imagination either to mask the brutal facts, by day-dreaming, having pleasant thoughts, or diverting their attention by using guided imagery; or trying and to imagine additional solutions to the problem that go beyond the facts—improvisation and surely arts and creative methods, improvisation, and humor.

The fifth type will rely on their B-belief and values to guide them through times of stress or crisis: not only religious belief, but also political stands beliefs or feeling of the mission (meaning), as well as the need for self-fulfillment and strong "self" expressions. The last group will use some physiological focus methods-Ph. These are people who mainly react and cope by using physical expressions together with body movement. Their methods of coping with stress may include meditation, relaxation, desensitization, sports, hikes, drinking, eating, smoking, and taking medications.

Following the formation of our BASIC Ph model, based on the previously mentioned interviews, we were looking for an "outside validation" of our concept. Thus, we reviewed hundreds of studies on coping or related issues and tried to see whether their results can be categorized according to the BASIC Ph Model. In 2012, we performed a much larger Internet and sites search (Leykin, 2013) and found similar results to the first review. As was expected, some of the studies found more than just one dominant mode, because people use more than a single mode.

The following is an example of those early studies and their classifications:

B, Ph: The way of coping and managing a single stressor or multiple risk factors, the decisive question being whether a person merely reacts or also acts (e.g., Rutter, 1985).

C, B: A low tendency toward problem avoidance or fatalism (e.g., Lösel & Köferl, 1989).

B, C: Cognitions, self-efficacy, and self-esteem (e.g., Rutter, 1985. (A, S: Availability of an emotionally stable and trustworthy person during early childhood; e.g., Brandt, 1984.)

A, C: The ability of the child to accept delay in gratification (e.g., Murphy, 1987).

I, C: Curiosity, motivation and joy in exploratory behavior already as an infant, as well as motivation to observe and listen (e.g., Murphy, 1987).

C: Higher IQ (e.g., Felsman & Vaillant, 1987).

S: Socially competent behavior, despite chronic stress; helpfulness; popularity with peers and taking on of responsibility for siblings and sometimes also for ill parents (e.g., Werner, 1989).

Ph: Physical attractiveness, particularly in girls (e.g., Cunningham, 1986).

Thus, we saw that BASIC Ph Model could serve as a model for understanding coping and resilience and made it into a practical model.

The Psycholinguistic Aspect of the BASIC Ph Model

Once we had the model and found some support from other researchers, we were satisfied with the idea that people have a variety of coping resources but were struggling with how to quickly assess these models to guide crisis support or crisis intervention. It was then that we realized that if we listen to the way a person describes his or her experience, we can trace their coping "channel" by simply listening to the content and the way the story is built.[3] We tried it out in various real events and then in studies conducted by myself and Leykin (2013).

Stressful situations challenge our abilities and coping resources. If the stress is either very severe (a personal appraisal) or prolonged, we may find that some people cannot cope and that their resources were either exhausted or ineffective. Under circumstances where repeated attempts to cope do not avail, the situation could turn into a crisis. Sometimes it is a sudden major incident that finds the person weak (physically or emotionally), depleted, or unprepared to meet the challenge, and causes the distress or even the posttraumatic reaction.

There are times when in a crisis the individual uses "more of the same patterns" to rid themselves of the distress, but find these coping attempts are not effective anymore. In other words, a person becomes set in the mold (or rut), using the same mode of coping endlessly, neither progressing nor changing anything. In this case, the crisis stems from being stuck or from inflexibility. It is fair to state that although many symptomatically react at the onset of the crisis, we need to remember that the vast majority of people recover on their accord (Cherry et al., 2015). That is to say that for the majority of those who react, the symptoms displayed during the acute phase are not "ill"; simply, their current distress is too hard for them to cope with or contain and these symptoms will subside in reasonable time. As we know, out of those who seek help in the acute phase Acute Stress Reaction (ASR), not many will stay for lengthy treatment, most will be seen once or twice, some will meet with us a few times, and

[3] Indeed, some will find certain similarities to the Neuro Linguistic Programming (NLP) model of Bandler and Grinder (1979); however, they refer to the Neuro, which are the sense that governs the absorption of information (visual, tactile, auditory). We focus on the Psycho linguistic, which is aspects such as cognition, emotions, imagination, and more.

a minority will have a longer treatment as needed. Besides, it is questionable as to what crisis intervention should contain, are we interfering with the natural course of healing when we intervene too early and too much? It is only after 9–11 that studies indicated we need to focus and activate the coping resources of the client (McNally, Bryant, & Ehlers, 2003)

In light of this, we concluded that the best practice of acute intervention should be to start with tracing and then communicate with the affected person through his or her apparent language (Figure 1), which is the way they meet the world, so that we could focus on strength and known patterns of relating the inside out in order to make sense. We call it "interventions based on the quick assessment of the client's coping modalities." This is mostly based on careful listening to the client's modes of recounting the incident. Based on this quick resource assessment, we provide feedback to the client using questions to see if we "hit" the right coping modes, confirm to him or her their abilities, and check whether that is correct. We found that this is what most ASR clients need.

Furthermore, this type of listening continues throughout the process even, with those who stay for an elaborate intervention or trauma-focused therapy. The main difference is that if the intervention based on the client's apparent modes of "meeting the world" does not prove effective within 3 to 4 weeks, we may suggest moving to other modalities. In this case, we will base our short-term psychotherapy on adjacent modes or forgotten modes (see Lahad, Shacham, & Ayalon, 2013).

The practical difference between crisis intervention and short-term therapy will be that in crisis intervention, the therapist will use the models that he found to be active based on the BASIC Ph model. For example, if the client used Cognitive and Social modes, we will ask questions like "Would you like to know what will happen next?" "Do you have any idea of what you want to do next?" "Do you need more information/explanation?" Moreover, on the S channel: "Do you know anyone here, whom would you like to notify/call to come and be with you?" We will refrain from using models that were not apparent such as Imagination or Belief system as the first choice.

In short-term psychotherapy, the therapist combines resourceful work (i.e., communicating through the apparent modes) with additional focus on channels that were less active (such as B or Ph in the previous example) and on the negative aspects or ineffective outcomes of the attempt to cope with the situation, encouraging the client to expand his existing modes as well as less active BASIC Ph channels referred in the model as "adjacent language" or even "forgotten language."

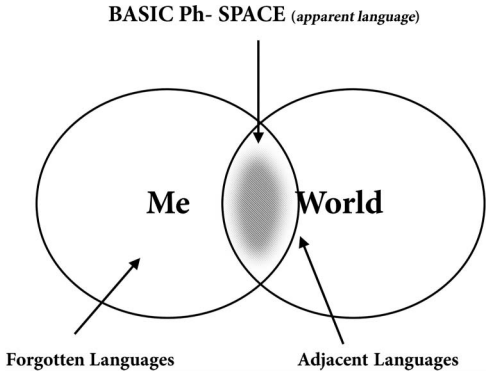

Figure 1. The Psycho-linguistic Model of BASIC Ph.

In this way, we established the BASIC Ph model as a framework that enables the therapist to assess and connect with the client's strengths, and at the same time, serves as a map to decide whether to suffice with crisis intervention; that is, to stay with the operating modes or to introduce new modes. This aspect of the model is widely used by emergency rooms in hospitals in Israel and abroad, as well as by first responders and mental health providers worldwide (see Figure 2).

Measuring the BASIC Ph

There are three ways of assessing the BASIC Ph modes (languages) of the client. First is a clinical psycholinguistic option described previously, focusing on the "apparent language" that is the modes operating at that given moment. This assessment is based on the assumption that the clients will describe their experience using the most developed/available modes they have. This will be the basis for the crisis intervention.

The second method of assessment is the Six Part Story-Making—projective technique, described in detail in Lahad, Shacham, and Ayalon (2013). Analyzing the verbatim based on the BASIC Ph categorization, the therapist is able to decide on the best course of operation; that is, to go for an intervention that is focusing only on apparent language or to devise a treatment plan based on the adjacent (less developed models) or the forgotten (modes that the client does not use).

The third way is a metric assessment of the BASIC Ph using Q-sort statements on a 5-point Likert scale. (Leykin, 2013). The first attempt to transform the BASIC Ph model into a self-report inventory was carried by Craig (2005) in his doctoral dissertation. Craig's transituational (i.e., an incorporation of both dispositional and situational aspects of coping), the 36-item instrument consisted of six items representing six hypothesized factors on the new Multi-Modal Coping Inventory (MMCI). Craig's (2005) study was the only one to examine the test–retest reliability of the MMCI, which was found adequate over 4–6 weeks. Further evaluation of the validity of the MMCI yielded several significant associations with measures of well-being (i.e., The Mental Health Inventory; Veit & Ware, 1983), as well as with other coping measures (i.e., Coping Orientation with Problem Experiences Inventory; Carver, Scheier, & Weintraub, 1989). When examining its' criterion-related validity, five MMCI dimensions (all but the A mode) were found to have adequate to strong concurrent validity as indicated by moderately strong positive correlations with dimensions of the COPE Inventory (Carver et al., 1989) that had similar item consistency (Craig, 2005).

The Cross-Sectional Study of BASIC Ph

To further explore the configuration of BASIC Ph model in the broader population, Leykin (2013) conducted a cross-sectional study to investigate BASIC Ph manifestation among the Israeli Jewish population. The short MMCI-Revised (18 items) was administered online together with the Brief Resiliency Scale (BRS, six items; Smith et al., 2008). Final data analysis was conducted on 949 individuals (n = 512 female and 437 male) between the ages of 15 and 65.

The most dominant coping mode among the whole population was the Cognitive channel, and the second most dominant mode was the

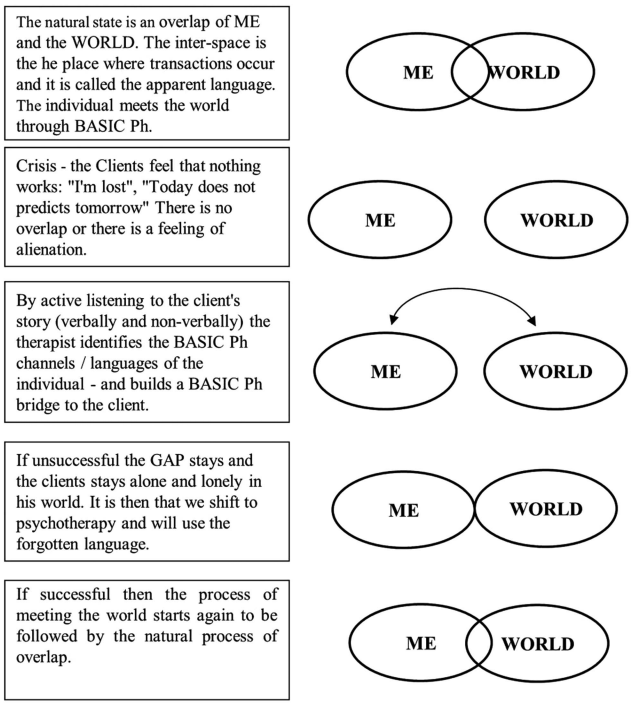

Figure 2. Crisis intervention according to the BASIC Ph Model.

Social channel. The cognitive channel was significantly more dominant than the other channels. The least dominant coping mode statistically found among the participants was the Imaginative channel.

Correlates of BASIC PH Model

When examining gender effects on coping models, statistically significant effects were observed for all modes. On five out of six channels females outscored males, the most significant different was found on the Affective mode, while men utilized more frequently the cognitive coping mode than women did.

These findings are from previous studies suggesting that women are more likely than men to engage in most coping strategies (Tamres, Janicki, & Helgeson, 2002). The described gender effects were emerged in later studies as well using similar scale (Erez & Laviod, 2011; Gelber & Dodek, 2011).

A series of recent research studies investigated the association between BASIC Ph and mental well-being among various civil and first responders populations. Erez and Laviod (2011) examined psychological correlates of BASIC Ph and tested associations between coping modes and self-efficacy, optimism and locus of control, which are psychological constructs related to resilience, and found significant and positive correlations between *belief* and optimism on the on hand, and between *cognition* and trait resilience on the other. Gelber and Dodek (2011) examined associations between coping modes, trait anxiety, self-efficacy, and social support among college students and found that self-efficacy had a negative correlation with *effect* and positive correlation with *cognition*. Perceived social support was positively associated with *cognition* but negatively with *physiology*. Ogni Ben-Dov, and Cohen (2011) explored ways of coping with sexual harassments and its relation to psychopathology among Israeli adult women. Controlling for peritraumatic distress and history of sexual harassments, utilizing belief and imagination resources during the most prominent sexual harassment incident predicted present posttraumatic symptoms. Utilization of positive emotional coping (also assessed in this study) interacted with peritraumatic distress, thus high levels of positive affect during the event predicted less posttraumatic symptoms when peritraumatic distress was great. Participants exceeding the threshold on the Impact of Event Scale (IES-R; Weiss & Marmar, 1997) for probable posttraumatic stress disorder (PTSD) significantly were more likely to utilize all coping modes, except positive affect coping.

Applications of the BASIC Ph Model

The Basic Ph model has been used as a model for a variety of projects and practices.

To name but few: (a) General hospital's emergency room protocol for ASR intervention (Lahad Kutz, 2004); (b) comprehensive local authority preparedness training of the psycho-social, health, and education interdisciplinary teams (Lahad & Ben Nesher, 2008); (c) the impact of mass media on the audience in critical incidents and how to use it for enhancement of public resiliency (Lahad, Shacham, & Niv, 2000); (d) the development of a new role for the home front command, the emergency behavior officer as a consultant to commanders and other decision-makers and its application to civic and commercial settings (Lahad, Rogel, & Crimando, 2012); (e) developing international postdisaster psychosocial recovery programs (Lahad et al., 2011; Shacham, 2013; Rogel, 2013); (f) school-based resiliency training and preparedness (Ayalon, 2013; Ayalon & Lahad, 1990; Krkeljic & Pavlicic, 2013; Lugovic, 2013); (g) helping parents to enhance resiliency for their kids (Kaplansky & Lahad, 2013; Lahad & Kaplansky, 2005; (h) Crisis intervention with various target groups; with children (Ayalon, 2013), women living under ongoing threat of rocket attacks (Spanglet & Tal-Margalit, 2013), and the application to small- and medium-sized business (Elmaliach, 2013).

One of the most rewarding experiences with this model has been the ability to use it in diverse cultures and places around the globe. The fact that both in Sri Lanka, Japan, and Europe professionals and paraprofessionals who were exposed to the model as a map for coping and resiliency found the most useful or almost the most useful tool they received and implemented in the field is for me an affirmation of its cross-cultural sensitivity and applicability (Lahad & Leykin, 2015). In Japan, an NGO called BASIC Ph Japan was formed as an outcome of the training post the tsunami of 2011 (see https://ja-jp.facebook.com/BasicPh/).

Conclusion

Over 35 years ago my journey into trauma crisis coping and recovery began. I truly hoped some 15 and 20 years ago that I would be able to move on and leave this themes behind, but the older I grew I realized the amount of suffering is not reduced, the extent of people exposed to traumatic incidents is not lessened, and that my small mission to help as long as I can, has not ended. Indeed, I developed many more creative methods to help in non-Western cultures (Lahad et al., 2011); how to organize international, cross-cultural intervention (Cohen & Lahad, 2014); and a protocol to treat PTSD using imagination and playfulness (see Far

cognitive–behavioral therapy method for the treatment of PTSD; Lahad & Doron, 2010) as Creative methods to be used in supervision (Lahad, 2000) helping children and youth cope with fears and anxiety (Lahad & Ankor, 1994).

I have managed, supervised, developed, and trained many crisis intervention projects and teams. I have been fortunate to witness and study the amazing phenomena of how individuals, families, groups, and communities recover from traumatic events. These studies and surveys never failed to amaze me and help me to admire the spirit of humankind. My leitmotif is a Confucius proverb, which I keep close to mind to remind me of the purpose of my work and the way I meet the world despite all that I have been through personally and all the many pains, hurts, and sorrow I have witnessed and tried to alleviate:

> "*You cannot prevent the birds of sorrow from flying over your head, but you can prevent them from building nests in your hair.*"

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