Deanship of graduate studies

AL-Quds University

Secondary Trauma among Health Professionals Working at Emergency Departments in Gaza-Strip

Nader Ahmed Matter

M.P.H Thesis

Jerusalem – Palestine

2010 – 1431

AL-Quds University

Deanship of graduate studies

School of Public Health

Deanship of graduate studies

AL-Quds University

Secondary Trauma among Health Professionals Working at Emergency Departments in Gaza-Strip

Nader Ahmed Matter

M.P.H Thesis

Jerusalem – Palestine

2010 - 1431

AL-Quds University

Deanship of graduate studies

School of Public Health

Secondary Trauma among Health Professionals Working at Emergency Departments in Gaza-Strip

Prepared by:

Nader Ahmed Matter

Supervisor:

Dr. Abdel Aziz Mousa Thabet, MD, PhD

Associate Professor of Psychiatry
School of Public Health

A thesis submitted in partial fulfillment of requirement for the degree of
Master degrees of community mental health

At The School of Public Health – Gaza

Al-Quds university-Palestine

2010

AL-Quds University

Deanship of graduate studies

School of Public Health

Thesis Approval

Secondary Trauma among Health Professionals Working at Emergency Departments in Gaza-Strip

Prepared by: Nader Ahmed Matter
Registration No:20812767

Supervisor: Dr. Abdel Aziz Mousa Thabet, MD, PhD
Associate Professor of Psychiatry, School of Public Health

Master degrees thesis submitted and accepted: Date 02 / 10 / 2010

The names and signatures of the examining committee member are as follows:

Head of Committee:	**Dr. Abdel Aziz Thabet**	**Signature**
Internal Examiner:	**Dr. Mohamed El-Khatep**	**Signature**
External Examiner:	**Dr. Ahmed Abu Twahena**	**Signature**

Jerusalem - Palestine

1431/2010

بسم الله الرحمن الرحيم

" قُلْ إِنَّ صَلاَتِي وَنُسُكِي وَمَحْيَايَ وَمَمَاتِي لِلّهِ رَبِّ

الْعَالَمِينَ، لاَ شَرِيكَ لَهُ وَبِذَلِكَ أُمِرْتُ وَأَنَا أَوَّلُ الْمُسْلِمِينَ "

صدق الله العظيم

سورة الأنعام[162]

Dedication

I dedicate this work to the Palestinians who are still making life

possible to face the Israeli aggression and violation against their civil and political rights, and to my father and, mother and my wife for holding the excitement and energy to finish this work.

Declaration

I certify that this thesis submitted for the degree of Master in community mental health, is the result of my own research, except where otherwise acknowledged, and

that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed:
Nader Matter
Date: 15/07/2010

Acknowledgements

I would like to express my sincere gratitude to my respected teacher and my academic supervisor, Dr.Abdel. Aziz Thabet, Associated professor of psychiatry , AL Quds University, for his guidance, supervision, and encouragement in carrying out this

research work . He has been constant source of inspiration in all stages of this work. I am highly indebted to him for his advice and continuous guidance.

Special deep thanks and acknowledge go to all my teachers in the school of public health who gave me support and guidance .

I would like to thank several people who helped me and provided helpful recommendation and suggestion during the process of writing this work.

I would like to thank my wife for being always available. And particularly for supporting me over the past two years. I thank my family for holding the excitement and energy I needed to finish this work.

I also wish to thank my friends Mr. Yousef Fahajan, and colleagues who gave me helpful and grounded support during the study period .

I would like to acknowledge the effort of the nurses and doctors in hospitals for their help during data collection and to all workers for their willingness to participate in this study.

Finally, I would like to express my sincere thanks and appreciation to the hidden hands who assisted me throughout the study period, this study would not have been done without their support .

Abstract

Aim: To determine secondary trauma among health professionals working at emergency departments in Gaza-Strip and to investigate the relationship between

secondary trauma experienced by health professionals working at emergency department and anxiety.

Method: The researcher used descriptive analytic method for data by using structured tools as Socio-demographic status questionnaire, Secondary Trauma Check list, and Hamilton Anxiety Scale. The study sample include all the doctors and nurses working at emergency department in Gaza Strip from this hospitals. The study consisted of (n=214) professional workers (n=193) male 90.2% and (n=21) female 9.8%, and (n=78) doctors 36.4%, and (n=136) nurses 63.6%.

Results: The results also showed professional workers had arousal symptoms (irritability reported by 75% of professional workers), followed by Avoidance symptoms (avoidance of patients 71.5%), and intrusion symptoms (intrusive thoughts about patients 70%). the prevalence of secondary trauma among emergency professionals worker. In this sample 85% reported at least 1 secondary trauma symptom. 45% of the sample met the criterion for a diagnosis of secondary trauma.

Also there was strongly significant correlation between the means of secondary trauma and anxiety symptom, and show that there is strongly statistically significance between the means of secondary trauma and education level (p-value =0.007), the highest secondary trauma effect was on master (mean = 2.6) and the lowest was on practical nurse (mean = 1.9).

. Strongly significant (p-value 0.032**)** between the means of secondary trauma and years of experience, the highest secondary trauma effect was on those with 6-15 years of experience (mean = 2.6) and lowest was on those with 5 and below (mean = 1.3).

مدى تأثير الصدمة الثانوية على موظفي أقسام الطوارئ في مستشفيات قطاع غزة

الملخص:

الهدف : تحديد الصدمة الثانوية في صفوف المهنيين الصحيين العاملين في أقسام الطوارئ في قطاع غزة ، والكشف عن العلاقة بين الصدمة الثانوية عند المهنيين الصحيين العاملين في قسم الطوارئ القلق .

استخدم الباحث المنهج الوصفي التحليلي لعرض البيانات الخاصة بمجتمع العينة. كما استخدم عدة مقاييس معدلة و متلائمة مع غرض و هدف الدراسة منها: مقياس الحالة الاجتماعية و الاقتصادية (إعداد الباحث), ومقياس الصدمة الثانوية, ومقياس هاملتون القلق.

عينة الدراسة تشمل جميع الأطباء والممرضات العاملين في قسم الطوارئ في قطاع غزة من هذه المستشفيات , مستشفى بيت حانون, ومستشفى كمال عدوان، و مجمع الشفاء الطبي , و مستشفى شهداء الأقصى، و مجمع ناصر الطبي، و مستشفى غزة الأوروبي، و مستشفى أبو يوسف النجار .وقد كان مجتمع الدراسة 214 موظف مهني, 193 من الذكور (90.2٪), و 21 من الإناث(9.8 ٪), و 78 من الأطباء (36.4 ٪), و 136 من التمريض (63.6٪) .

النتائج : أظهرت النتائج أن الموظفين المهنيين الذي لديهم أعراض الإثارة (التهيج التي أبلغ عنها 75 ٪ من الموظفين المهنيين) ، تليها تجنب الأعراض (تجنب المرضى 71.5 ٪) ، وأعراض التسلل (أفكار متطفلة حوالي 70 ٪) من المرضى. معدل انتشار الصدمات الثانوية بين المهنيين العاملين في أقسام الطوارئ في هذه العينة 85 ٪ الذين ظهر عليهم على الأقل عرض واحد من أعراض الصدمة الثانوية. و أن 45 ٪ من العينة ينطبق عليهم تشخيص الصدمات الثانوية .

أيضا كان هناك دلالة إحصائية قوية بين الصدمات الثانوية ، أعراض القلق و الخبرة الصادمة ، وتبين أن هناك دلالة من الناحية الإحصائية بقوة بين وسائل الصدمات الثانوية والمستوى التعليمي.

List of Abbreviations

CF	**Compassion Fatigue**
CSTD	**Constructive Self Development Theory**
PTSD	**Post-Traumatic Stress Disorder**
STS	**Secondary Trauma Stress**
STSS	**Secondary Trauma Stress Scale**
VT	**Vicarious Trauma**

Table of Content

Subject	**Page**
Declaration	I

	Acknowledgements	II
	Abstract	III
	ملخص باللغة العربية	IV
	List of Abbreviations	V
	Table of Content	VI
	List of table	X
	List of Figures	XI
	List of Appendices	XI

Chapter One

No.		
1.1	Overview & background	2
1.2	Purpose of the study & problem statement	4
1.3	Significance of the study	4
1.4	Aim of the study	5
1.5	Objectives of the study	5
1.6	Research questions	5
1.7	Definitions of variables	6
1.7.1	Definition of secondary trauma	6
1.7.2	Health professional workers	7
1.7.3	Emergency department	7
1.7.3.1	Hospitals have emergency department in Gaza strip	8
1.7.3.2	Al Shifa Medical Complex	8
1.7.3.3	Kamal Adwan Hospital	8
1.7.3.4	Beit hanoun Hospital	8
1.7.3.5	Al Aqsa Martys Hospital	9
1.7.3.6	Nasser Medical Complex	9
1.7.3.7	European Gaza Hospital	9
1.7.3.8	Abu Yousef Al-Najjar Hospital	9
1.7.4	Gaza Strip	10
1.7.5	Mental health	10

Chapter Two
Conceptual framework& literature review

2.1	Part 1: Theoretical framework	12
	Definitions	13
2.2	Definition of secondary trauma	13
2.2.1	Symptoms of secondary trauma	14
2.3	Definition of trauma	14
2.3.1	Traumatic stress	15
2.3.2	Trauma victim	15
2.3.3	The impact of trauma	15
2.3.4	Types of trauma	16
2.3.5	Categories of traumatic events	16
2.3.5.1	Responsibility categorizations	16
2.3.5.2	Cause categorizations	17
2.3.6	Developmental trauma	17
2.3.7	Situational trauma	18
2.3.8	Nature of event categorization	18

2.3.9	Natural disasters	18
2.3.10	Personal loss	18
2.3.11	Health trauma	19
2.3.12	Victimization	19
2.3.13	Criminal violence	19
2.3.14	Wars and terrorism	19
2.3.15	Effects of traumatic experiences	19
2.3.16	Common effects of trauma	20
2.3.16.1	Re-experiencing symptoms	20
2.3.16.2	Avoidance symptoms	22
2.3.17	Risk factors that increase your vulnerability to trauma	22
2.3.18	Definition of anxiety	23

Part 2: literature review

2.4	Trauma theory	25
2.4.1	Psychological trauma	25
2.4.2	Evolutions legacy	25
2.4.3	The fight-or-flight response	26
2.4.4	Learned helplessness	27
2.4.5	Loss of "volume control"	27
2.4.6	Thinking under stress - action not thought	29
2.4.7	Remembering under stress	29
2.4.8	Emotions and trauma - dissociation	32
2.4.9	Endorphins and stress -addiction to trauma	35
2.4.10	Trauma-bonding	36
2.4.11	Traumatic reenactment	37
2.4.12	Trauma and the body	38
2.4.13	Victim to victimizer	39
2.4.14	Issues of meaning and spirituality	39
2.4.15	Creating sanctuary	40
2.5	Secondary trauma theory	41
2.5.1	Background	41
2.5.2	The CSDT is based on the following assumptions	42
2.5.2.1	Constructivism	42
2.5.2.2	Individual differences	42
2.5.2.3	Developmental perspective	42
2.5.3	According to the CSDT there are five aspects of the self that are impacted by psychological trauma	42
2.6	Theories of Anxiety	45
2.6.1	Genetic theory	45
2.6.2	Psychodynamic theory	46
2.6.3	Learned behavioral theory	47
2.6.4	Biochemical theory	47
2.6	Studies review	49
2.6.1	Background	49
2.6.2	Studies concern with secondary trauma	49
2.6.3	Studies concern with vicarious trauma	51
2.6.4	Studies concern with burnout	56
2.6.5	Studies concern with compassion fatigue	57
2.6.6	Studies concern with Post-traumatic stress	60

Chapter Three: Methodology

3.1	Introduction	62
3.2	Study design	62
3.3	Study population	62
3.4	Study sample	62
3.5	Period of the study	63
3.6	Eligibility criteria	63
3.6.1	Inclusion and exclusion criteria	63
3.7	Ethical considerations	64
3.8	Data-collection instrument	64
3.8.1	Socio-demographic status (developed by the researcher)	64
3.8.3	Secondary trauma check list	64
3.8.4	Hamilton anxiety scale	64
3.9	Reliability	66
3.9.1	Reliability for secondary trauma check list	66
3.9.2	Reliability for Hamilton anxiety scale	66
3.10	Advantages of questionnaires	66
3.11	Data entry and statistical analysis	67

Chapter Four
Results

4.1	Characteristics of the sample	69
4.2	The frequency of anxiety scale	72
4.2.1	The severity and prevalence of anxiety symptom among study sample	73
4.3	Description of secondary trauma.	74
4.3.1	The prevalence of secondary trauma among the study sample	75
4.4	Relationship between secondary trauma and anxiety symptom according to socio-demographic variables	75
4.4.1	Differences between secondary trauma and anxiety symptom according to sex	76
4.4.2	Relationship between secondary trauma and anxiety symptom according to age group	77
4.4.2.1	Comparison between secondary trauma and anxiety symptom according to age group	78
4.4.3	Relationship between secondary trauma and anxiety symptom according to social status	79
4.4.4	Relationship between secondary trauma and anxiety symptom according to place of residence	80
4.4.4.1	Comparison between secondary trauma, traumatic events, and anxiety symptom according to place of residence	81
4.4.5	Relationship between secondary trauma and anxiety symptom according to type work	82
4.4.6	Relationship between secondary trauma and anxiety symptom according to education level	83
4.4.6.1	Comparison between secondary trauma and anxiety symptom according to education level	84

4.4.7	Relationship between Secondary trauma and anxiety symptom according to hospitals	85
4.4.7.1	Comparison between secondary trauma, traumatic events, and anxiety symptom according to hospitals	86
4.5	Differences between Secondary trauma and anxiety symptom according to years of Experience	87
4.5.1	Comparison between secondary trauma and anxiety symptom according to experience	88
4.6	Correlation between secondary trauma and anxiety among the study sample	89

Chapter Five
Discussion and recommendations

	Introduction	91
5.2	The main results	91
5.3	Discussion	94
5.4	Recommendations	98
	Reference	99

List of tables

No.	Table content	Page
4.1	Samples Distribution According to Socio-demographic	71
4.2	Frequency of anxiety symptom Hamilton anxiety scale	72
4.3	The severity and prevalence among of symptoms	73
4.4	Secondary trauma scale	74
4.5	The prevalence of secondary trauma of the study sample	75
4.6	Differences between Secondary trauma, and anxiety symptom according to sex	76
4.7	One-way ANOVA comparison between secondary trauma and anxiety symptom according to age	77
4.8	Mean of secondary trauma and anxiety symptom according to age group	78
4.9	One-way ANOVA comparison between secondary trauma and anxiety symptom according to social status	79
4.10	One-way ANOVA comparison between secondary trauma and anxiety symptom according to place of residence	80
4.11	Mean of secondary trauma and anxiety symptom according to place of residence	81
4.12	Independent t-test comparison between secondary trauma and anxiety symptom according to type of work	82
4.13	One-way ANOVA comparison between secondary trauma and anxiety symptom according to education level	83
4.14	Mean of secondary trauma and anxiety symptom according to education level	84
4.15	One-way ANOVA comparison between secondary trauma and anxiety symptom according to hospitals	85
4.16	Mean of secondary trauma, and anxiety symptom according to hospitals	86

4.17	One-way ANOVA comparison secondary trauma and anxiety symptom according to experience	87
4.18	Mean of secondary trauma and anxiety symptom according to experience	88
4.19	Correlation between secondary trauma and anxiety among the study sample	89

List of Figures

No.	Figures	Page
2.1	Conceptual framework diagram	12
3.1	Distribution the sample according to sex and type of work	63

List of Appendices

No.	Annexes	Page
1	Hamilton anxiety scale	105
2	Secondary traumatic stress scale	106
3	Questionnaire of the study	107
4	Helsinki Committee	110
5	Facilitate the task of student	111
6	Map of Gaza strip	112

Chapter One

Introduction

Chapter One

Introduction

1.1 Overview and background

Exposure to human suffering by professional workers is common in the emergency departments. On any day, emergency professional workers care for an array of patients, varying in age, injury, and disease process. They commonly see patients with injuries sustained in motor vehicle crashes, assaults, rapes, abuse and from gunshot wounds. Emergency professional workers may experience negative repercussions after caring for these types of patients with the cumulative effect of chronic exposure to patients in physical or psychological distress, in conjunction with an empathetic response. A potential consequence of such "caring" work is a negative and profound effect on professional workers health that is sometimes referred to as compassion fatigue (CF) or secondary traumatic stress (STS). CF was first described as "a unique form of burnout," where people in the care giving professions are the most susceptible. The concept was further developed as the emotional stress experienced (professionals' workers) from the trauma of another (patient) and has been described as the "emotional residual" of working with people who are suffering or traumatized. Both STS and CF refer to exposure to a person or persons who are traumatized or suffering rather than exposure to a previous traumatic events itself. CF has an acute onset and results from caring for people who are suffering rather than a toxic work environment. It may occur after multiple interactions with "traumatized and troubled" patients, resulting from the desire to help the traumatized persons. War on Gaza strip and other long standing conflicts increased the risk of developing secondary trauma and consequently the effects on professions working with victims of war and trauma which lead to secondary trauma. Secondary trauma occurs and affects people during their lifetime. Traumatized individual usually seeks assistance from health personnel, consequence of working at emergency departments top help them in coping with traumatic experiences. According to Figley (1999), traumatized people often complain that their friends and family discourage them from articulating their experiences, as it is too distressing for them to hear. Health professionals working at emergency departments shares their compassion with these traumatized people

because of their care nature (Schwam, 1998). Health professionals working at emergency departments assists those individuals affected by trauma (Figley, 1999). Health professionals working at emergency departments and other health care workers who are exposed to others' trauma in their daily work are often traumatized and overburdened by narratives and events that happened to others. According to McCann and Pearlman (1990), health professionals working at emergency departments will give meaning to previous traumatic events depending on how they as individuals experience them. These interpretations of the previous traumatic events can result in health professionals working at emergency departments' experiencing changes in the way they view themselves, others and their world. McCann and Pearlman (1990) coined the term "secondary trauma" to describe the disruptions in cognitive schemes (i.e., core beliefs about self, others and the world) and behavioral changes experienced by health professionals working at emergency departments who treat the traumatized (Steed & Bicknell 2001). Secondary trauma is an occupational hazard for health professionals working at emergency departments and other health persons who care for and support trauma survivors (Pearlman & Saakvitne, 1995). Neuman and Gamble (1995) showed that health professionals working at emergency departments experiencing secondary trauma begin to see the world through "trauma lenses" and Pearlman and Maclan, (1995) suggested that continuous exposure to trauma survivors sustains this view. The focus is usually on the effects of trauma on the primary victims and not on those who care for and support them (secondary victims) (Galea, Ahern, Resnick & Kilpatrick, 2002; Kleijn, Hovens & Rodenburg, 2001; Kubany 2002; Leskela, Dieperink & Thuras, 2002). Because secondary victims are not directly involved in the previous traumatic events, their distress often goes undetected (Brady, Guy, Poelstra & Brokaw, 1999). Shifts in this approach have to occur, as these secondary victims need to be assisted in their role as counselors, so that they can continue to help the primary victims to cope with their trauma. Cunningham (2003), (McCann and Pearlman, 1990), and Pearlman and Saakvitne (1995) focus on the personal trauma history of people who counsel the traumatized. The effects of secondary trauma experienced by health professionals working at emergency departments need to be understood in the context of the work environment.

1.2 Problem statement

Secondary trauma is an important occupational hazard for health professionals working at emergency departments as the effects accumulate and may change how the

health professionals work at emergency departments view themselves and their world. The effects of secondary trauma experienced by health professionals working at emergency departments, the relationship between personal trauma history and secondary trauma, and support systems need to be investigated as health professionals working at emergency departments who are overburdened with work and stress and their own trauma have little resources left to care for and comfort others . So, this study aims to investigate impact of secondary trauma on anxiety of health professionals working at the emergency departments.

1.3 Significance of the study

The significant of this study is that it would document the prevalence of secondary trauma among health professionals working at emergency departments who render a mental health service. Furthermore, whether there are relationships between secondary trauma and mental health of professionals working at emergency departments. This study may raise the awareness of health policy makers to help those professionals in overcoming their ability to cope with the effects of secondary tramatization. In addition, it should create an awareness of the shortcomings in the support of health professionals working at emergency departments in the hospital field. The findings may facilitate future planning of additional support, which could be rendered to health professionals working at emergency departments in the areas where they work with violence and diseases in the emergency departments. Collins and Long (2003) suggested that self-awareness programmers should be a core focus for persons rendering a counseling service to victims of trauma. Collins (2001) pointed out that a counseling service was offered to professionals workers following the Omagh Bombing in Northern Ireland, and although support and counseling cannot be forced on anyone, this service should be available. Staffs, who feel the need to access this service, should be encouraged to do so and not be made to feel a failure for not coping. Ongoing staff training should include information on vicarious trauma and self-care strategies to ameliorate the effects of vicarious trauma (Way, Van Deusen, Martin, Applegate & Jandle, 2004). Psychological debriefing is a structured intervention that promotes the emotional processing of secondary trauma through normalizing feelings and preparing the individual for possible future experiences.

1.4 Aim of the study

The overall aim of the study is to investigate the effects of secondary trauma experienced by health professionals working at emergency departments on their feeling of anxiety.

1.5 Objectives of the study

The objectives of this study are to:

- To find the type and severity of secondary trauma that affects the health professionals working at emergency departments.
- To investigate the effect of secondary traumatization on health professionals working at emergency departments and other socioeconomic variables.
- To find the type and severity of anxiety that affects the health professionals working at emergency departments.
- To find the relationship between secondary trauma, anxiety and socioeconomic variables.
- To reach a recommendations for health policy makers for better planning and services.

1.6 Research questions

To achieve the aim, the study wishes to answer the following research questions :

- What is the type and severity of of secondary trauma that affects the health professionals working at emergency departments?
- Are there effect of secondary traumatization on health professionals working at emergency departments and other socioeconomic variables?
- What is the severity of anxiety that affects the health professionals working at emergency departments?
- Are there relationship between secondary trauma, anxiety and socioeconomic variables?

1.7 Definitions of variables

For the purposes of this study, the following terms are used as defined below :

1.7.1 Definition of secondary trauma

Secondary trauma is "the psychological consequence resulting from repeated exposure to the patient's traumatic experience" (Schauben & Frazier, 1995). Pearlman and Maclan (1995) define secondary trauma as "disruptions to the therapist's inner experience, as a result of repeated exposure to the clients' traumatic narratives". In this study, secondary trauma is the psychological disruptions to the health professional workers inner experience, as a result of repeated exposure to the clients' traumatic narratives.

Various terms have been used to describe the stress resulting from helping a traumatized person, including "secondary traumatic stress," "compassion fatigue," (Figley, 1995, 1999) and "vicarious traumatization/trauma" (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Wilson and Lindy (1994) described this experience as a form of posttraumatic stress disorder (PTSD) among therapists, who without direct exposure to a traumatic event will display symptoms almost identical to those of PTSD. Herman (1997) referred to this response as traumatic countertransference, from which the therapist experiences the same terror, rage, and anguish as the patient, albeit to a lesser degree. Following Pearlman and Saakvitne (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Saakvitne & Pearlman, 1996), the current study conceptualizes vicarious trauma as a process involving a transformation in the inner experience of the therapist resulting from empathic engagement with clients' traumatic material. Whereas countertransference is present in all therapeutic relationships with dynamics unique to each therapist-client dyad, vicarious traumatization is a cumulative consequence not specific to any one client, which can be lasting and linked to multiple aspects of the therapist's personal and professional life (Saakvitne, 1996). Taxing psychological effects can interfere with the therapist's adaptive assumptions of personal security and a meaningful world (Chrestman, 1999; Kassam-Adams, 1999), increasing the likelihood of a protective numbing reaction to feelings of pain and loss (Saakvitne, 1996).

1.7.2 Health professional workers

Staff members from hospital establish obligatory shifts to cover emergency rooms.

Staff in emergency room work on shifts coming from other departments of the hospital, there is no doctors' permanent staff to emergency room, except head of emergency. But nurses staff is permanent to emergency room. The number of staff assigned in a normal situation, around 3-4 doctors from different specialties in the emergency medicine, around 1-3 doctors in the surgical emergencies, 2, 3, 4, nurses by shift (night, evening, and day), with an 8 hours shifts.

1.7.3 Emergency departments

Emergency departments are a dedicated area in a hospital that is organized and administered to provide a high standard of emergency care to people in the community who perceive the need for, or are in need of, acute or urgent care including hospital admission (Australian College for Emergency Medicine, 2004).

Staffing of emergency departments must include registered professionals workers on duty, on-site access to medical officers and on-call access to a senior doctor at all times. There will also be on-call access to specialist medical services and/or arrangements for the transfer of patients to receive those services when needed. Emergency departments require access to the services of allied health staff and 24 hour access to pathology, radiology and operating theatre services. Patients using emergency department services may initially deal with reception and then be triaged or assessed for their level of urgency. Once inside the departments they receive an initial assessment followed by stabilization and management of their condition. They may then be discharged home or to another service or admitted to a hospital ward for further treatment possibly via the operating theatre. There are different definitions and classifications of emergency departments for different purposes. The only nationally consistent definitions are the role delineations of the Australian College for Emergency Medicine, which categories emergency departments by their role and level of function. These categories are major referral, urban district and major regional / rural base emergency departments. Two further categories — the rural emergency service and primary care / remote rural emergency service relate to hospital-based services that are too small or under equipped to be considered emergency departments.

1.7.3.1 Hospitals that have an emergency departments in Gaza strip:

1. Beit Hanoon Hospital.

2. Kamal Odwan Hospital.
3. Al Shifa Medical Complex.
4. Al Aqsa Martys Hospital.
5. Nasser Medical Complex.
6. European Gaza Hospital.
7. Abu Yousef Al-Najjar Hospital.

1.7.3.2 Al Shifa Medical Complex

This medical complex includes three hospitals: the hospital, surgery and hospital Internal Medicine and Obstetrics & Women's Hospital with a clinical capacity of 500 beds. Al Shifa complex is situated in the central west of Gaza City, at the crossroads of the intersection of Izz al-Din Qassam Street with El-Wahda Street. It was built in 1946 on an area of 42000 m2, and serves as the coverage area of the Governorate of Gaza, with a population of 496 411 people, in particular, and Gaza strip. The number of staff of the hospital 1201 employees (Hospitals Annual Report, 2008).

1.7.3.3 Kamal Odwan Hospital

It is a general hospital that provides surgical services and internal medicine and pediatrics, with a capacity of 73 beds. It is located in Beit Lahia in box No. 7, and it has been established in 2002 on an area of 5000 m2, and serves the segment of the population living in the northern Gaza Strip with a population of about 270,246 people, and the number of hospital staff in all specialties, is 300 employees (Hospitals Annual Report, 2008).

1.7.3.4 Beit Hanoun Hospital

It is a general hospital that provides surgical services, internal and children, with a capacity of about 36 beds. It is located in the center of the town of Beit Hanoun, and it was founded in 2006 on an area of 2500 m2, and serves the segment of the population living in the town of Beit Hanoun and its neighborhood with a population of 50000 people, and the number of hospital staff in all specialties, 192 employees (Hospitals Annual Report, 2008).

1.7.3.5 Al Aqsa Martyrs Hospital

General hospital that provides surgical services and internal medicine, children, women and obstetrics, with a capacity of 103 beds. It is located in the central governorate of Deir al-Balah. It was established in 2001 on an area of 4000 m2, and serves the segment of the population residing in the province middle zone Gaza strip, whose population is about 205,535 people, and the number of hospital staff in all specialties, is 392 employees (Hospitals Annual Report, 2008).

1.7.3.6 Nasser Medical Complex

It is a general medical complex that includes two hospitals, namely: Nasser (Internal Medicine and Surgery) and Mubarak Hospital (Obstetrics & women, and children) with a clinical capacity of 258 beds. The complex is situated in the western area of Khanyunis, Sea Street, and it has been established in 1958 on an area of 50000 m2, and serves the area of coverage in Khan Yunis, with a population of 270,979 people, and the compound has a staff of all specialties, is 742 employees (Hospitals Annual Report, 2008).

1.7.3.7 European Gaza Hospital

It is a located in the southern Gaza strip and it offers services for surgery and internal medicine and children. Clinical capacity is a total of 207 beds. The hospital is located in the south-eastern town of Khan-Yunis area of the Al-Fokhary Street crossing and has been established in 1987 on an area of 65000 m2, and serves the area east of Khan-Yunis, the northern region of Rafah. The number of hospital staff in all specialties, is 709 employees (Hospitals Annual Report, 2008).

1.7.3.8 Abu Yousef Al-Najjar Hospital

The hospital provides services in surgery and internal medicine, children, and the clinical capacity is 40 beds. The hospital is located in the neighborhood of embryonic Street crossing in Rafah, has been established in 2000 to an area of 4000 m 2, and serves the segment of the population living in the Rafah governorate with a population of 173,372 people, and the number of hospital staff in all specialties, a total of 226 employees (Hospitals Annual Report, 2008).

1.7.4 Gaza strip

It is about 41 kilometers (25 mi) long, and between 6 and 12 kilometers (4–7.5 mi) wide, with a total area of 378 square kilometers. The area is recognized internationally as part of the Palestinian territories.

1.7.5 Mental health

Mental health is more than the mere lack of mental disorders. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals. Mental health should be a concern for all of us, rather than only for those who suffer from a mental disorder. Mental health problems affect society as a whole, and not just a small isolated segment. They are therefore a major challenge to global development. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education, victims of violence, migrants and refugees, indigenous populations, children and adolescents, abused women and the neglected elderly. For all individuals, mental, physical and social health is closely interwoven, vital strands of life. As our understanding of this interdependent relationship grows, it becomes ever more apparent that mental health is crucial to the overall well-being of individuals, societies and countries. Unfortunately, in most parts of the world, mental health and mental disorders are not accorded anywhere the same importance as physical health. Rather, they have been largely ignored or neglected (American Psychiatric Association, 2000).

Chapter Two

Conceptual Framework&

Literature Review

Chapter Two

Conceptual framework& literature review

2.1 Part 1: Theoretical framework

In this chapter the researcher presents the conceptual framework which consists of two parts. The first part concerns with theoretical framework and definitions of secondary trauma, trauma and anxiety where as the second part a talk about literature review contains theories and studies review. Also the researcher tried to draw the relations between them as the researcher expected; as shown in the following Figure

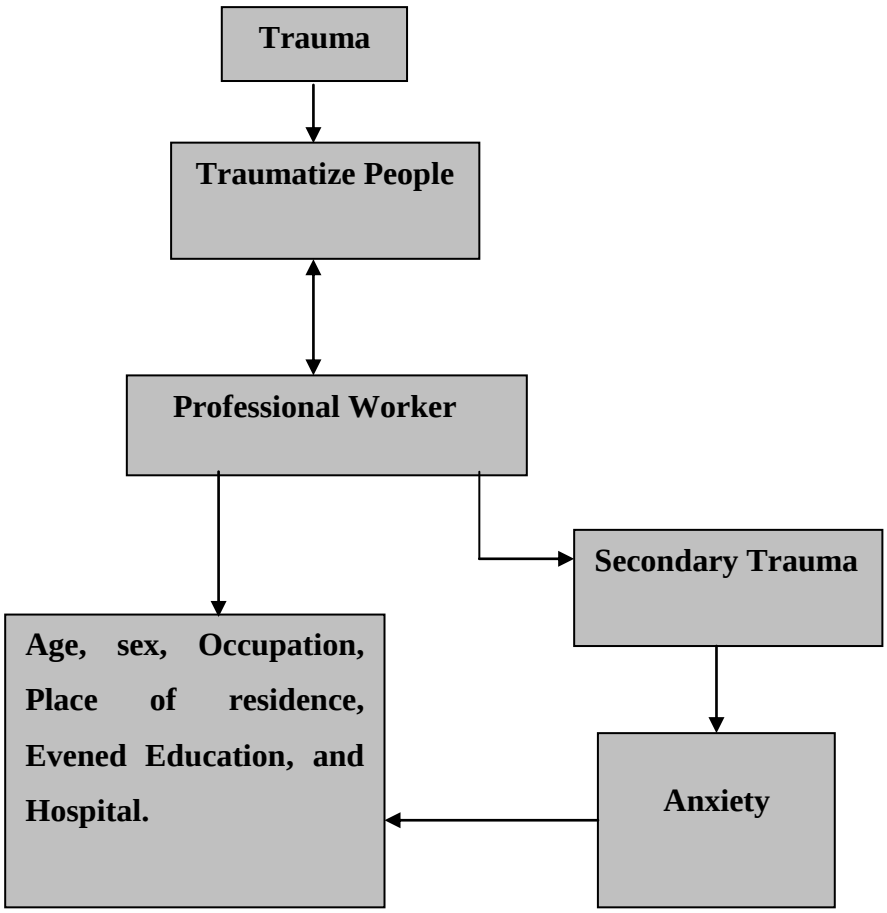


Figure (2.1): Conceptual framework diagram

Definitions

2.2 Definition of secondary trauma

Secondary trauma is a term that was used previously in non-professionals workers disciplines, such as social work, and reflects the emotional disequilibrium resulting from close contact with persons who are victims of trauma. Defined as the presence of post-traumatic stress disorder (PTSD) symptoms in the caregiver, secondary trauma results from a combination of the caregivers' own previous traumatic experiences and the experiences of their patients. Secondary trauma may occur after daily exposure to traumas in conjunction with the empathetic response. CF and STS disorder are used interchangeably, with persons suffering from symptoms identical to those in PTSD (but only differing by exposure), based on the American Psychological Association's definition of traumatic stress disorders. Related terms are vicarious traumatization and burnout (Sabo, 2006).

Vicarious traumatization refers to an empathetic engagement with trauma suffered by persons cared for that alters providers' "inner experience" and implies a negative and potentially permanent impact over time.

Burnout is defined as a "syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment referring to a gradual wearing down of an individual provider because of imbalance between expected and actual work experiences. Nelson-Gardell and Harris imply that burnout is the presence of symptoms such as fatigue; irritability, indifference, and poor work performance related to organizational issues. All of these terms reflect a potential impact on professionals workers related to care giving that comes from their empathetic interactions with suffering or traumatized patients. Little is known about the effects workers experience when caring for patients and their families who are experiencing suffering or trauma, especially day after day. With STS, health care providers may experience PTSD symptoms, a combination of caregivers' own traumatic experiences and the experiences of their patients. STS is related to CF but does not have an acute onset, as described by Sabo 2006.

High levels of STS may lead to professional workers burnout and job turnover or separation from professional workers. There has been no quantitative exploration of STS in emergency workers. Therefore the purpose of this study was to explore the prevalence of STS in a group of emergency workers in Gaza strip.

Trauma is generally defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or

a threat to self or others' physical well-being (American Psychiatric Association, 1999). Secondary trauma is an element of compassion fatigue (CF). And has another name vicarious trauma (VT). **Secondary trauma** is "the psychological consequence resulting from repeated exposure to the patient's traumatic experience" (Schauben & Frazier, 1995). Pearlman and Maclan (1995) define **secondary trauma** as "disruptions to the therapist's inner experience, as a result of repeated exposure to the clients' traumatic narratives". In this study, secondary trauma is the psychological disruptions to the health professionals working at emergency departments ' inner experience, as a result of repeated exposure to the clients' traumatic narratives. According to the constructive self development theory (CSDT), these psychological disruptions have an effect on how the health professionals working at emergency departments view themselves and their world.

2.2.1 Symptoms of secondary trauma

- Physical effects – increased heart rate, dizziness, migraine, high blood pressure.
- Emotional distress (anger, guilt, fear, grief, despair, shame, irritability, paranoia and inability to contain intense emotions).
- Feelings off cynicism, sadness and seriousness.
- No time energy for self or others.
- Anxiety.
- Decision – making capacity & attention span.
- Sense of vulnerability (e.g. When home alone / driving at night).
- Sensitivity to violence (e.g. When watching the news).
- Self destructive and or anti- social behavior.

2.3 Definition of trauma

"Trauma is a psychologically distressing event that is outside the range of usual human experience. And that induces an abnormally intense and prolonged stress response often involves a sense of fear, terror and helplessness (Perry, 2006).

2.3.1 Traumatic stress

It is the stress resulting from exposure to, or witnessing of events that are severe

and/or life threatening. The extent of traumatic stress experiences varies by duration of exposure and number of exposures. Additionally, the amount of stress incurred will vary according to the availability of resources and coping skills (Terr, 1990).

2.3.2 Trauma victims

They are the individuals who are impacted by a traumatic occurrence?

Primary Trauma Victims: individuals who are directly involved in the trauma. **Secondary Victims**: individuals who are indirectly impacted by the trauma. These include relatives and loved ones, members of the immediate community or surrounding area, and of course may include relief workers and persons who respond to the incident, and people who experience the trauma through the media (Perry, 2006).

2.3.3 The impact of trauma

Until quite recently, people believed that children were not affected by trauma because they were "too young to remember or understand" what had happened to them. It is now clear that exposure to previous traumatic events can affect all aspects of development - physical, emotional, social, psychological and cognitive - even in babies. It is also known that every child who is exposed to a previous traumatic events will experience and respond to it in his or her own way, depending on their age, developmental stage, the type of the previous traumatic events(s) and the social environment surrounding the child (Fitzgerald Rice & Groves, 2005).

Experience the effects of trauma in varying ways may include some or all of the following:

- Disrupted attachment relationships
- Rapid behavioral regressions i.e. behaviors that are too young for their age.
- Failure to achieve developmental competencies or milestones.
- Anticipatory behavior and traumatic expectations e.g. a fear response with a loud noise.
- Lack of capacity for emotional self-regulation i.e. an inability to calm themselves or control emotions.
- Aggressive behavior against self and others
- Disrupted sleep, eating, and self-care

- Multiple somatic problems, from upset tummies to headaches
- Self-hatred and self-blame
- Feelings of low self worth and hopelessness.
- Poor social skills
- Tend to be withdrawn, or to bully other children
- Apparent lack of awareness of danger and resulting self endangering behaviors.
- Avoidance and controlling behaviors

2.3.4 Types of trauma

Simple: This type of trauma is usually caused by a single incident. The incident is usually one that involves life threatening events and/or events that have the potential to cause serious injury. Examples: car accident, fire cyclone, and shooting.

Complex: This type of trauma is usually longer in duration and involves multiple incidents. The incidents are usually ones that involve interpersonal violence or violation and as a result they are almost always associated with a sense of shame and stigma. Examples:' All forms of child abuse, bullying, experiences of war, Imprisonment (Meichenbaum, 1994).

2.3.5 Categories of previous traumatic events

It. is important to have understanding of the different categories of trauma. There are three categories of trauma:

2.3.5.1 Responsibility

There have been many attempts to categorize trauma. This categorization of traumatic occurrences generally is organized by: who or what is responsible for the trauma, the cause of the trauma, or categorizations as well as the factors which impact the severity of trauma and traumatic responses. Crises may be viewed as either natural, or human-made. Natural crises include those disasters that are created by the forces of nature such as tornados, hurricanes, and floods. When the cause is viewed as human made, the reactions may be more emotionally devastating. Human made tampering, chemical attacks, ethnic cleansing, riots and wars, suicide, murder, crime and violence. This is likely because the disaster is viewed as within the control of individual persons, and

therefore avoidable. It is not only the acts themselves, but the threat of these acts which may have psychologically traumatizing impact. Society at large is at risk due to close proximity of persons in public and working spaces such as office buildings, public transportation and public events. Globally, people around the world have begun to see themselves as vulnerable.

Natural Disasters include natural disasters such as tornados, hurricanes, fires, earthquakes, typhoons, floods, and tsunamis.

Human-made Disasters include building/structural collapse, medical/food tampering, chemical attacks, ethnic cleansing, riots and wars, suicide, murder, terrorism, crime and violence (Yule & Williams 1990).

2.3.5.2 Cause categorizations

Events that lead to trauma may be expected, such as the death of a family member who is terminally ill, or unexpected, such as the terrorist attack. Trauma can additionally be categorized as part of normal development such as when children leave their parents' home, or they can be specific to an unanticipated situation (Yule, & Williams, 1990).

2.3.6 Developmental trauma

.These crises are predictable because they occur as part of the maturation process. Developmental theorists believe that people progress through a series of life stages. During each of the life stages, there are particular tasks which must be resolved in order for the person to develop in a healthy fashion. If a person fails to accomplish the necessary task they may experience crises related to the lack of meeting developmental criteria. Developmental theorists include Freud, Kohlberg, and Piaget . For example, if during young adulthood a person fails to learn how to sustain committed and intimate relationships they will likely be unsatisfied in future relationships and find that they lack intimate connectedness with others. Developmental crises might also include 'mid-life crises' or 'empty-nest syndrome.'

2.3.7 Situational trauma

These result from unanticipated events that are extraordinary in nature. These may happen at any time in one's life and can include natural disasters such as tornado's and hurricanes, or they can be man-made disasters such as the terrorist attacks, suicides, automobile accidents, train crashes etc.

2.3.8 Nature of event categorization

Categorization by the nature of the event varies, but in general, researchers attempt to group specific traumatic incidences into categories that reflect the pervasive shared elements of particular trauma. Thus, while most trauma involves loss, specific types of loss are viewed as having some common elements which impact upon the severity of the trauma and the severity of the reaction to the trauma. Factors which may increase traumatic severity include: predictability, controllability and intensity. Additionally, the reaction to trauma is impacted by the prolonged, repeated, or individual nature of the event or situation (Yule, & Williams, 1990).

2.3.9 Natural disasters

They include natural disasters such as tornados, hurricanes, fires, earthquakes, typhoons, floods, and tsunamis. These disasters may have low predictability (such as fires and earthquakes) or there may be some advance notice giving people time to take precautions or vacate. The occurrence of natural disasters is generally considered to have no or little controllability although there may be some control over impact.

2.3.10 Personal loss

The most prevalent type of trauma is that of the loss of a person who has played a key role in the person's life. Losses may also include pets, jobs, or any familiar object or environment. This includes loss due to death, divorce, and separation. Separations can be marital, parental, siblings, or other important support persons. Intensity of this trauma varies by the intensity of the relationship with the person, object, or life situation. Repeated personal losses without sufficient recovery time complicate and intensify the reaction.

2.3.11 Health trauma

It includes trauma due to the onset of disability or illness. Intensity is affected by the severity of the disability or illness and the effects upon typical and routine functioning and may also be affected by issues of self-blame. If the individual blames the disability on their own behaviors (driving under the influence of alcohol or participating in unprotected sexual activity) the trauma may be viewed by the individual as having high controllability.

2.3.12 Victimization

Physical or emotional trauma results from abuse or neglect. This includes: physical abuse, sexual abuse, and neglect. Victimization can be repeated, prolonged, or a single event. These may subject the individual to a prolonged period of perceived or actual life threatening situations which increases the intensity of the event. Victims may blame themselves for behaviors prior or during the trauma increasing the perception of controllability.

2.3.13 Criminal violence

Victims are subject to individual events such as robbery and homicide, and criminal assault in which they experience a lack of control over their belongings and/or their bodies and may have been subjected to a life threatening situation. Re-victimization may compound reactions.

2.3.14 Wars and terrorism

Many of these are intense, massive in scale, and long-term in nature exposing victims to 'repeated life-threatening situations. Additionally, persons may have engaged in perpetrating violence against others. This may intensify the response to trauma because the perpetration can be seen as counter to the self-image. It may be particularly distressful if it comes to be viewed as an avoidable and controllable occurrence.

2.3.15 Effects of traumatic experiences

When people find themselves suddenly in danger, sometimes they are overcome with feelings of fear, helplessness, or horror. These events are called traumatic experiences. Some common traumatic experiences include being physically attacked, being in a serious accident, being in combat, being sexually assaulted, and being in a

fire or a disaster like a hurricane or a tornado. After traumatic experiences, people may have problems that they didn't have before the event. If these problems are severe and the survivor does not get help for them, they can begin to cause problems in the survivor's family. This fact sheet explains how traumas can affect those who experience them. This fact sheet also describes family members' reactions to the previous traumatic events and to the trauma survivor's symptoms and behaviors. Finally, suggestions are made about what a survivor and his or her family can do to get help for PTSD. People who go through traumatic experiences often have symptoms and problems afterward. How serious the symptoms and problems are depends on many things including a person's life experiences before the trauma, a person's own natural ability to cope with stress, how serious the trauma was, and what kind of help and support a person gets from family, friends, and professionals immediately following the trauma (Yule, & Williams, 1990). Because most trauma survivors are not familiar with how trauma affects people, they often have trouble understanding what is happening to them. They may think the trauma is their fault, that they are going crazy, or that there is something wrong with them because other people who experienced the trauma don't appear to have the same problems. Survivors may turn to drugs or alcohol to make themselves feel better. They may turn away from friends and family who don't seem to understand. They may not know what to do to get better.

2.3.16 Common effects of trauma

During a trauma, survivors often become overwhelmed with fear. Soon after the traumatic experience, they may re-experience the trauma mentally and physically. Because this can be uncomfortable and sometimes painful, survivors tend to avoid reminders of the trauma. These symptoms create a problem that is called posttraumatic stress disorder (PTSD). PTSD is a specific set of problems resulting from a traumatic experience and is recognized by medical d mental-health professionals (De Silva, 1999).

2.3.16.1 Re-experiencing symptoms

Trauma survivors commonly re-experience their traumas. This means that the survivor experiences again the same mental, emotional, and physical experiences that occurred during or just after the trauma. These include thinking about the trauma,

seeing images of the event, feeling agitated, and having physical sensations like those that occurred during the trauma. Trauma survivors find themselves feeling as if they are in danger, experiencing panic sensations, wanting to escape, getting angry, and thinking about attacking or harming someone else. Because they are anxious and physically agitated, they may have trouble sleeping and concentrating. The survivor usually can't control these symptoms or stop them from happening. Mentally re-experiencing the trauma can include upsetting memories such as images or thoughts about the trauma, feeling as if the trauma is happening again (flashbacks), bad dreams and nightmares, getting upset when reminded about the trauma (by something the person sees, hears, feels, smells, or tastes), anxiety or fear, feeling in danger again, anger or aggressive feelings and feeling the need to defend oneself, trouble controlling emotions because reminders lead to sudden anxiety, anger, or upset, and trouble concentrating or thinking clearly

People also can have physical reactions to trauma reminders such as trouble falling or staying asleep, feeling agitated and constantly on the lookout for danger, getting very startled by loud noises or something or someone coming up on you from behind when you don't expect it, feeling shaky and sweaty, and having your heart pound or having trouble breathing. Because trauma survivors have these upsetting feelings when they feel stress or are reminded of their trauma, they often act as if they are in danger again. They might get overly concerned about staying safe in situations that are not truly dangerous. For example, a person living in a safe neighborhood might still feel that he has to have an alarm system, double locks on the door, a locked fence, and a guard dog. Because traumatized people often feel like they are in danger even when they are not, they may be overly aggressive and lash out to protect themselves when there is no need. For example, a person who was attacked might be quick to yell at or hit someone who seems to be threatening.

Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience. These symptoms are automatic, learned responses to trauma reminders. The trauma has become associated with many things so that when the person experiences these things, he or she is reminded of the trauma and feels that he or she is in danger again. It is also possible that re-experiencing symptoms are actually a part of the mind's attempt to make sense of what has happened (De Silva, 1999).

2.3.16.2 Avoidance symptoms

Because thinking about the trauma and feeling as if you are in danger is upsetting, people who have been through traumas often try to avoid reminders of the trauma. Sometimes survivors are aware that they are avoiding reminders, but other times survivors do not realize that their behavior is motivated by the need to avoid reminders of the trauma (De Silva, 1999).

Avoiding thoughts, feelings, and sensations associated with the trauma can include actively avoiding trauma-related thoughts and memories, a voiding conversations and staying away from places, activities, or people that might remind you of the trauma, trouble remembering important parts of what happened during the trauma, shutting down emotionally or feeling emotionally numb, trouble having loving feelings or feeling any strong emotions, finding that things around you seem strange or unreal, feeling strange, feeling disconnected from the world around you and things that happen to you, avoiding situations that might make you have a strong emotional reaction, feeling weird physical sensations, feeling physically numb, not feeling pain or other sensations, and losing interest in things you used to enjoy doing.

Trying to avoid thinking about the trauma and avoiding treatment for trauma-related problems may keep a person from feeling upset in the short term, but avoiding treatment means that in the long term, trauma symptoms will persist (De Silva, 1999).

2.3.17 Risk factors that increase vulnerability to trauma

Not all potentially previous traumatic events lead to lasting emotional and psychological damage. Some people rebound quickly from even the most tragic and shocking experiences. Others are devastated by experiences that, on the surface, appear to be less upsetting. A number of risk factors make people susceptible to emotional and psychological trauma. People are more likely to be traumatized by a stressful experience if they're already under a heavy stress load or have recently suffered a series of losses. People are also more likely to be traumatized by a new situation if they've been traumatized before - especially if the earlier trauma occurred in childhood (De Silva, 1999).

2.3.18 Definition of anxiety

Anxiety is an unpleasant emotional state, the sources of which are less readily identified. It is frequently accompanied by physiological symptoms that may lead to fatigue or even exhaustion. Because fear of recognized threats causes similar unpleasant mental and physical changes, patients use the terms fear and anxiety interchangeably (Greist and Jefferson, 2000).

The intensity of anxiety has many gradations ranging from minor qualms to noticeable trembling and even complete panic, the most extreme form of anxiety.

The course of anxiety also varies, with peak severity being reached within a few seconds or more gradually over minutes, hours, or days. Duration also varies from a few seconds to hours or even days or months, although episodes of panic usually abate within 10 minutes and seldom last more than 30 minutes (Marks, 1987).

If anxiety arises unexpectedly ("out of the blue"), it is called uncured or spontaneous anxiety (or if very intense, spontaneous panic). When anxiety occurs predictably in response to specific situations, it is called cued, phobic, or situational anxiety (or when extreme, phobic or situational panic). Anticipatory anxiety (or anticipatory panic) is the term used to describe anxiety triggered by the mere thought of particular situations (Greist and Jefferson, 2000).

Because anxiety disorders are chronic 111 natures, typically displaying patterns of exacerbation and remission often associated with life stress, these patients form a substantial core of the practices of primary care physicians (PCPs) (Barlow, 200 I; Brown & Barlow, 1995).

The boundary between normal and pathological anxiety cannot be drawn with great precision or confidence. People sometimes seek treatment for anxiety only to find that the anxiety has disappeared before treatment begins. Physicians sometimes delay treatment until disruption of functioning is obvious or suffering is severe (Paul et al, 1980).

These differences are understandable in the context of present knowledge regarding anxiety, attitudinal differences of both patients and doctors about seeking and giving help, and the effectiveness of various treatments. When anxiety substantially impairs work or social adjustment, most authorities agree that careful assessment is indicated and that treatment is likely to be worthwhile. Suffering itself is often justification for treatment, even if the person with anxiety can continue to function (Greist and Jefferson, 2000).

Anxiety commonly occurs as a manifestation of appropriate concern about medical

and psychiatric disorders. Medical problems involving any body system can produce anxiety as a symptom. Drugs and dietary factors-e--particularly caffeine and alcohol may also provoke anxiety.

The majority of patients suffering from anxiety and other psychological disorders in primary care settings are not recognized, and even fewer are treated effectively. There are significant numbers of such patients, and their anxiety disorders often have a chronic and persistent course, especially panic disorder with agoraphobia, posttraumatic stress disorder (PTSD), and social anxiety disorder (Weisberg, Culpepper, & Keller, 2002).

2.4 Trauma theory

2.4.1 Psychological trauma

To understand what trauma does we have to understand what it is. Lenore Terr, a child psychiatrist who did the first longitudinal study of traumatized children writes, "Psychic trauma occurs when a sudden, unexpected, overwhelming intense emotional blow or a series of blows assaults the person from outside. Previous traumatic events are external, but they quickly become incorporated into the mind' (Terr, 1990). Van der Kolk makes a similar point about the complicated nature of trauma when he says, "Traumatization occurs when both internal and external resources are inadequate to cope with external threat' (Van der Kolk, 1989). Both clinicians make the point that it is not the trauma itself that does the damage. It is how the individual's mind and body reacts in its own unique way to the traumatic experience in combination with the unique response of the individual's social group.

Children are traumatized whenever they fear for their lives or for the lives of someone they love. A traumatic experience impacts the entire person - the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world are all profoundly altered by traumatic experience (Terr, 1990).

2.4.2 Evolution’s legacy

It is impossible to fully understand human behavior and the human response to trauma without grasping key insights about the way our evolution has affected us. The fight-or-flight response described below is a part of our mammalian heritage, and continues to profoundly impact, at a physiological level, our response to all stresses, even those caused by our sophisticated social environments. We are born with a number of innate emotions that are also part of our mammalian heritage and that produce patterned and predictable responses in all of our organs, including our brain. This means that overwhelming emotions can do damage to our bodies as well as our psyches. As a species we survived largely because we developed as social animals for mutual protection and this social nature of human beings is grounded in our need to attach to other human beings from cradle to grave. Children who suffer disrupted attachments may suffer from damage to all of their developmental systems, including their brains and we are particularly ill-suited to having the people we are attached to also be the

people who are violating us. Our very complex brains and powerful memories distinguish us as the most intelligent of all animals, and yet as we will see, it is this very intelligence that leaves us vulnerable to the effects of trauma such as flashbacks, body memories, post-traumatic nightmares and behavioral reenactments. The social nature of our species is guaranteed by an innate sense of reciprocity that can be observed even among primates. But this same sense of "fair play" leads not only to the evolution of justice systems, but also to the need for revenge. The result is that you cannot hurt anyone, most importantly children, without setting the stage for revenge that will be exacted either upon themselves, upon others, or both. Finally, we are physiologically designed to function best as an integrated whole, just like the computers that we now build. The fragmentation that accompanies traumatic experience degrades this integration and impedes maximum performance in a variety of ways. Human brains function best when they are adequately stimulated but simultaneously protected from overwhelming stress. This explains our need for order, for safety, for adequate protection. Let's look more closely now at what trauma does to the minds and bodies of those involved (Terr, 1990).

2.4.3 The fight-or-flight response

We are animals and like other animals, we are biologically equipped to protect ourselves from harm as best we can. The basic internal protective mechanism is called the fight-or-flight reaction. Whenever we perceive that we are in danger our bodies make a massive response that affects all of our organ systems. This change in every area of basic function is so dramatic that in many ways, we are not the same people when we are terrified as when we are calm.

Each episode of danger connects to every other episode of danger in our minds, so that the more danger we are exposed to, the more sensitive we are to danger. With each experience of fight-or-flight, our mind forms a network of connections that get triggered with every new threatening experience. If children are exposed to danger repeatedly, their bodies become unusually sensitive so that even minor threats can trigger off this sequence of physical, emotional, and cognitive responses. They can do nothing to control this reaction - it is a biological, built-in response, a protective device that only goes wrong if we are exposed to too much danger and too little protection in childhood or as adults.

The real nature of the fight-or-flight response means that if we hope to help traumatized people, then we must create safe environments to help counteract the long-term effects of chronic stress (Seligman, 1992).

2.4.4 Learned helplessness

If a person is able to Master degrees the situation of danger by successfully running away, winning the fight or getting help, the risk of long-term physical changes are lessened. But in many situations considered to be traumatic, the victim is helpless and it is this helplessness that is such a problem for human beings. As a species, we cannot tolerate helplessness - it goes against our instinct for survival. We know from animal experiments, that helplessness can cause changes in the animals' ability to recognize and escape from danger so that once the animal becomes accustomed to trauma it fails to try and escape from danger. This has been called "learned helplessness".

Apparently, there are detrimental changes in the basic neurochemistry that allows the animal to self motivate out of dangerous situations. Change only occurs when the experimenter actively intervenes and pulls the animal out of the cage. At first, the animal runs back in, but after sufficient trials, it finally catches on and learns how to escape from the terror once again. The animals' behavior improves significantly, but they remain vulnerable to stress. As in human experience, animals show individual variation in their responses. Some animals are very resistant to developing "learned helplessness" and others are very vulnerable (Seligman, 1992).

We know that people can learn to be helpless too, that if a person is subjected to a sufficient number of experiences teaching him or her that nothing they do will affect the outcome, people give up trying. This means that interventions designed to help people overcome traumatizing experiences must focus on master degrees and empowerment while avoiding further experiences of helplessness.

2.4.5 Loss of "volume control"

The experience of overwhelming terror destabilizes our internal system of arousal - the internal "volume control" dial that we normally have over all our emotions, especially fear. Usually, we respond to a stimulus based on the level of threat that the stimulus represents. People who have been traumatized lose this capacity to "modulate arousal". They tend to stay irritable, jumpy, and on-edge. Instead of being

able to adjust their "volume control", the person is reduced to only an "on-or-off' switch, losing all control over the amount of arousal they experience to any stimulus, even one as un threatening as a crying child.

Children are born with only an on-or-off switch. Gradually, over the course of development and with the responsive and protective care of adults, the child's brain develops the ability to modulate the level of arousal based on the importance or relevance of the stimulus. This is part of the reason why the capacity of adults to soothe frightened children is so essential to their development. They cannot soothe themselves until they have been soothed by adults. Children who are exposed to repeated experiences of overwhelming arousal do not have the kind of safety and protection that they need for normal brain development. They may never develop normal modulation of arousal. As a result they are chronically irritable, angry, unable to manage aggression, impulsive, and anxious. Children - and the adults they become - who experience this level of anxiety will understandably do anything they can to establish some level of self-soothing and self-control.

Under such circumstances, people frequently turn to substances, like drugs or alcohol, or behaviors like sex or eating or even engagement in violence, all of which help them to calm down, at least temporarily. If you have never been able to really control your feelings, and you discover that alcohol gives you some sense of control over your internal states, it is only logical that you will turn to alcohol for comfort. The experience of control over helplessness will count for much more than anyone's warnings about the long-term consequences of alcohol abuse.

The implication of these findings for intervention strategies is that we need to understand that many of the behaviors that are socially objectionable and even destructive are also the individual's only method of coping with overwhelming and uncontrollable emotions. If they are to stop using these coping skills, then they must be offered better substitutes, most importantly, healthy and sustaining human relationships. Blaming and punishment is thus counterproductive to the goals that we hope to achieve - they just tend to make things worse (Alford, Mahone, and Fielstein, 1988).

2.4.6 Thinking under stress - action not thought

Our capacity to think clearly is also severely impaired when we are under stress. When we perceive that we are in danger, we are physiologically geared to take action, not to ponder and deliberate. In many situations of acute danger it is better that we respond immediately without taking the time for complicated mental processing, that we respond almost reflexively to save our lives or to protect those we love. When stressed, we cannot think clearly, we cannot consider the long-range consequences of our behavior, we cannot weigh all of the possible options before making a decision, and we cannot take the time to obtain all the necessary information that goes into making good decisions. Our decisions tend to be based on impulse and are based on an experienced need to self-protect. As a consequence these decisions are inflexible, oversimplified, directed towards action, and often are very poorly constructed (Janis, 1982). In such situations people demonstrate poor judgment and poor impulse control. The mind is geared towards action and often the action taken will be violent. Many victims have long-term problems with various aspects of thinking. An intolerance of mistakes, denial of personal difficulties, anger as a problem-solving strategy, hyper vigilance, and absolutistic thinking are other problematic thought patterns that have been identified (Alford, Mahone, and Fielstein, 1988).

In formulating intervention strategies, this means that every effort should be made to reduce stress whenever good decisions are sought. It also means that we need to look at the growing sources of social stress that are inflicted on individuals and families at home, in the workplace, and in the community and evaluate what kinds of buffers can be put into place that help attenuate the effects of these stressors.

2.4.7 Remembering under stress

Our way of remembering things, processing new memories, and accessing old memories is also dramatically changed when we are under stress. Still, there is a growing body of evidence indicating that there are actually two different memory systems in the brain - one for normal learning and remembering that is based on words and another that is largely nonverbal (Van der Kolle, 1996). Our verbally based memory system is vulnerable to high levels of stress. Under normal conditions, the two kinds of memory function in an integrated way. Our verbal and nonverbal memories are thus usually intertwined and complexly interrelated.

What we consider our "normal" memory is based on words. From the time we are born we develop new categories of information, and all new information gets placed

into an established category, like a filing cabinet in our minds. We talk in words, of course, but we also think with words. The person we identify as "me" is the person who thinks and has language. When we need to recall something, we go into the appropriate category and retrieve the information we need. But under conditions of extreme stress, our memory works in a different way.

When we are overwhelmed with fear, we lose the capacity for speech we lose the capacity to put words to our experience. Without words, the mind shifts to a mode of thinking that is characterized by visual, auditory, olfactory, and kinesthetic images, physical sensations, and strong feelings. This system of processing information may be adequate under conditions of serious danger. But the powerful images, feelings, and sensations do not just "go away". They are deeply imprinted, more strongly in fact, than normal everyday memories. The neuroscientist has called this "emotional memory" and has shown that this kind of memory can be difficult or impossible to erase, although we can learn to override some of our, this "engraving" of trauma has been noted by many researchers studying various survivor groups (Van der Kolle, 1996). Problems may arise later because the memory of the events that occurred under severe stress are not put into words and are not remembered in the normal way we remember other things. Instead, the memories remain "frozen in time" in the form of images, body sensations like smells, touch, tastes, and even pain, and strong emotions. A flashback is a sudden intrusive re-experiencing of a fragment of one of those traumatic, universalized memories. During a flashback, people become overwhelmed with the same emotions that they felt at the time of the trauma. Flashbacks are likely to occur when people are upset, stressed, frightened, or aroused or when triggered by any association to the previous traumatic events. Their minds can become flooded with the images, emotions, and physical sensations associated with the trauma and once again. But the verbal memory system may be turned off because of the arousal of fear, so they cannot articulate their experience and the nonverbal memory may be the only memory a person has of the previous traumatic events.

At the time of the trauma they had become trapped in "speechless terror" and their capacity for speech and memory were separated. As a result, they developed what has become known as "amnesia" for the previous traumatic events - the memory is there, but there are no words attached to it so it cannot be either talked about or even thought about. Instead, the memory presents itself as some form of nonverbal behavior and sometimes as a behavioral reenactment of a previous event. Even

thinking of flashbacks as "memories" is inaccurate and misleading. When someone experiences a flashback, they do not remember the experience, they relive it. Often the flashback is forgotten as quickly as it is happens because the two memory systems are so disconnected from each other.

Over time, as people try to limit situations that promote hyperarousa1 and flashbacks, limit relationships which trigger emotions, and employ behaviors designed to control emotional responses, they may become progressively numb to all emotions, and feel depressed, alienated, empty, and even dead. In this state, it takes greater and greater stimulation to feel a sense of being alive and they will often engage in all kinds of risk-taking behaviors since that is the only time they feel "inside" themselves once again.

If we cannot remember an experience we cannot learn from it. This is one of the most devastating aspects of prolonged stress. The implicit functioning of the brain, life-saving under the immediate conditions of danger, becomes life threatening when the internal fragmentation that is the normal response to overwhelming trauma, is not healed. The picture becomes even more complicated for children who are exposed to repeated experiences of unprotected stress. Their bodies, brains, and minds are still developing. We are only beginning to understand memory, traumatic memory, and how these memory systems develop and influence each other (Perry, 1993; Schwarz & Perry, 1994). We do know that children who are traumatized also experience flashbacks that have no words. For healing to occur, we know that people often need to put the experience into a narrative, give it words, and share it with themselves and others. Words allow us to put things into a time sequence - past, present, future.

Without words, the traumatic past is experienced as being in the ever present "Now". Words allow us to put the past more safely in the past where it belongs. Since a child's capacity for verbalization is just developing, their ability to put their traumatic experience into words is particularly difficult. In cases of childhood terror, language functions are often compromised. Instead, children frequently act-out their memories in behavior instead of words (James, 1994). They show us what happened even when they cannot tell us. We call this automatic behavioral reliving of trauma, "traumatic reenactment".

The implications of this important information about memory and trauma are extensive. It means that environments designed to intervene in the lives of suffering people must provide an abundance of opportunities for people to talk, and talk and

talk about their experiences, their past lives, their conflicts, their feelings. It means that programs that focus on nonverbal expression - a description that includes art, music, movement, and theatre programs as well as sports - are vital adjuncts to any community healing efforts and should be funded, not eliminated, in the schools. It means that the arts can play central role in community healing, serving as a "bridge across the black hole of trauma" (Bloom, 1996).

2.4.8 Emotions and trauma - dissociation

We don't usually think about it, but it is possible to die off right or to die of a broken heart. Every vital organ system is closely tied in through the autonomic nervous system, with our emotional system. In fact, however, people rarely die from emotional upsets. A fundamental reason for such rarity, despite the extent of fearful circumstances that children face, is the built-in "safety valve" that we call "dissociation".

Dissociation is defined as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment". Dissociation helps us do more than one thing at once. We can go on autopilot and automatically complete tasks that we have previously learned well, while we are focused on something else. This increase in efficiency may help explain why we evolved the ability. Traumatized people make special use of this capacity. There are different ways that people dissociate.

Fainting is an extreme form of simply stopping consciousness. Psychogenic fainting is the brain's way of saying, "I can't handle this". But we can also split off memories from consciousness awareness, as we have already discussed, and develop "amnesia". Rarely, someone can develop amnesia for their entire identity and begin a separate life - a fugue state. More commonly people develop amnesia for parts of their lives or just for parts of certain overwhelming experiences.

But there is another way we can dissociate that is so common that almost everyone does it - splitting off experience from our feelings about that experience. In its most extreme form, this is called "emotional numbing". So commonly do human beings cut off feelings about what happened to them while still remembering everything that often we have to look closely at the person before we see something is wrong they do not feel the emotions that would normally be expected under the circumstances? In such cases, instead of seeing the emotional numbing that has occurred to the person,

we will make comments about "how well Sheila is coping with her loss" or "how extraordinary it is that John never seems to get ruffled, even if someone is yelling at him". But Sheila and John are not necessarily "coping well" - they may be dissociated from their feelings and their capacity for normal emotional interaction may be consequently diminished.

We are able to cut off all our emotions but that usually happens only in extreme cases of repetitive and almost unendurable trauma. More commonly we cut-off or diminish specific emotional responses, based on the danger the emotion may present to continued functioning. Our emotions are intimately tied to the expression of emotion through our facial expressions, our tone of voice, our gestures, so that we easily give away what we may be consciously trying to hide. If you grow up in a violent home, where every time you express anger you get beaten, it is best that you never show anger. If you grow up in a home - or a culture - that says that little boys who cry are wimps who should be taught a "lesson", then it is a good idea to learn to never feel sadness, therefore minimizing the danger of tears. If any sign of pleasure or laughter is met with hostility and abuse, then it is best that you never feel joy. In this way, children from destructive situations learn how not to feel, they learn to dissociate their emotions from their conscious experience and their nonverbal expression of that emotion and in doing so, they can possibly stay safer than if they show what they feel. That does not mean that the emotion actually goes away. It does not. Emotions are built-in, part of our evolutionary, biological heritage and we cannot eliminate them, we can only transmute them. There is an abundance of evidence from various sources that unexpressed emotions may be very damaging to one's mental and physical health (Pennebaker, 1997).

It is certainly clear that emotional numbing is damaging to relationships. We need all of our emotions available to us if we are to create and sustain healthy relationships with other people. If we cannot feel anger, we cannot adequately protect others and ourselves. If we cannot feel sadness, we cannot complete the work of mourning that helps us recover from losses so that we can form new attachments. If we cannot feel joy, life becomes empty and meaningless leading to an increased potential for detachment, alienation, suicide and homicide. This is yet another example of how a coping skill that is useful for survival under conditions of traumatic stress can become a serious liability over time.

As this process continues over time, we gradually may shut-off more and more of our normal functioning. We may dampen down any emotional experience that could lead back to the traumatic memory. We may withdraw from relationships that could trigger off memories. We may curtail sensory and physical experiences that could remind us of the trauma. We may avoid engaging in any situations that could lead to remembering the trauma. At the same time, we may be compelled, completely outside of our awareness, to reenact the traumatic experience through our behavior. This increases the likelihood that instead of managing to avoid repeated trauma, we are likely to become traumatized again. As this process happens, our sense of which we are, how we fit into the world, how we relate to other people, and what the point of it all is, can become significantly limited in scope. As this occurs, we are likely to become increasingly depressed. These avoidance symptoms, along with the intrusive symptoms, like flashbacks and nightmares, comprise two of the interacting and escalating aspects of post-traumatic stress syndrome, set in the context of a more generalized physical hyper arousal. As these alternating symptoms come to dominate traumatized people's lives, they feel more and more alienated from everything that gives our lives meaning - themselves, other people, a sense of direction and purpose, a sense of spirituality, a sense of community. It is not surprising, then, that slow self-destruction through addictions, or fast self-destruction through suicide, is often the final outcome of these syndromes. For other people, rage at others comes to dominate the picture and these are the ones who end up becoming significant threats to the well being of others.

Children who are traumatized do not have developed coping skills, a developed sense of self, or self in relation to others. Their schemas for meaning, hope, faith, and purpose are not yet fully formed. They are in the process of developing a sense of right and wrong, of mercy balanced against justice. All of their cognitive processes, like their ability to make decisions, their problem-solving capacities, and learning skills are all still being acquired. As a consequence, the responses to trauma are amplified because they interfere with the processes of normal development. For many children, in fact, traumatic experience becomes the norm rather than the exception and they fail to develop a concept of what is normal or healthy. They do not learn how to think in a careful, quiet, and deliberate way. They do not learn how to have mutual, compassionate, and satisfying relationships. They do not learn how to listen carefully to the messages of their body and their senses. Their sense of self becomes

determined by the experiences they have had with caretaking adults and the trauma they have experienced teaches them that they are bad, worthless, a nuisance, or worse. Living in a system of contradictory and hypocritical values impairs the development of conscious, of a faith in justice, of a belief in the pursuit of truth. It should come as no surprise then, which these children so often end up as the maladjusted troublemakers that pose so many problems for teachers, schools, other children, and ultimately all of us. Again, the implications of this knowledge for intervention techniques and strategies are significant.

We must create systems that build and reinforce the acquisition of what Goleman has termed "emotional intelligence". We need to recognize that many of the maladaptive symptoms that plague our social environment are the result of the individual's attempt to manage overwhelming emotions, effective in the short-run, detrimental long-term. If we fail to protect children from overwhelming stress, then we can count on creating life-long adjustment problems that take a toll on the individual, the family, and society as a whole.

2.4.9 Endorphins and stress -addiction to trauma

These magical substances called endorphins are a part of normal, everyday functioning, but they are especially important during times of stress. Again, if we look at evolution, this makes sense. Not only does endorphins calm anxiety, improve our mood, and decrease aggression, but they also are great analgesics since they are related to morphine and heroin. Therefore, in times of stress, they provide enough pain relief that we are not disabled by injuries that would otherwise prevent us from escaping the danger. If people are only exposed to rare episodes of overwhelming stress, then they are less likely to show alterations in this biochemical system. Far more problematic are those people who are exposed to repeated experiences of prolonged stress. These people, often children, are exposed to repeatedly high levels of circulating endorphins. One hypothesis is that people can become "addicted" to their own internal endorphins and as a result only feel calm when they are under stress while feeling fearful, irritable and hyper aroused when the stress is relieved, much like someone who is withdrawing from heroin. This has been called "addiction to trauma" (Van der Kolle & Greenberg, 1987).

If this cycle is in place, then it helps us to understand many of the perplexing symptoms that have been incomprehensible without this information. Stress-addicted

children will be those children in the classroom who cannot tolerate a calm atmosphere but must keep antagonizing everyone else until the stress level is high enough for them to achieve some degree of internal equilibrium again. Violence is exciting and stressful and repeated violent acting-out, gang behavior, fighting, bullying, and many forms of criminal activity have the additional side effect of producing high levels of stress in people who have grown addicted to such risk-taking behavior. This also helps to explain self-mutilation in its many forms - these children and adults have learned that inflicting harm on the body will induce the release of endorphins that will provide some comfort, at least temporarily. These are children, who grow to be adults, unable to trust or be comforted by other people - in fact other people have been the fundamental source of the stress. Instead, they must fall back on whatever resources they can muster within themselves, resources that they can control, to achieve any kind of equilibrium. As adults, under stress, people who have been brutalized as children may again resort to behaviors that help induce some kind of alteration in the opioid system. These behaviors can include self-mutilation, risk taking behavior, compulsive sexuality, involvement in violent activity, bingeing and purging, and of course, drug addiction.

This recognition of the importance of addiction to trauma implies that intervention strategies must focus on helping people to this behavioral form of addiction by providing environments that insist on the establishment and maintenance of safety. Physiological stability cannot be achieved as long as the person is on an emotional roller coaster of stimulus and response

2.4.10 Trauma-bonding

Even more ominous for repeatedly traumatized people is their pronounced tendency to use highly abnormal and dangerous relationships as their normative idea of what relationships are supposed to be (Herman, 1992; James, 1994). Trauma-bonding is a relationship based on terror and the twisting of normal attachment behavior into something perverse and cruel. People, who are terrorized, whether as adult victims of torture, or domestic violence or child victims of family abuse, experience their abuser as being in total control of life and death. The perpetrator is the source of the pain and terror, but he is also the source of relief from that pain. He is the source of threat but he is also the source of hope.

This means that people who have been traumatized need to learn to create relationships that are not based on terror and the abuse of power, even though abusive power feels normal and right. In such cases, people often need direct relationship coaching and the direct experience of engaging in relationships that are not abusive and do not permit abusive and punitive behavior.

2.4.11 Traumatic reenactment

It has long been recognized that "history repeats itself', but never before have we so clearly understood why history does so. People who have been traumatized cannot heal themselves alone. It is one of the tragedies of human existence that what begin as life-saving coping skills end up delivering us into the hands of compulsive repetition. We are destined to reenact what we cannot remember. Freud called it the repetition compulsion and he said, "He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating ... He cannot escape idiom this compulsion to repeat; and in the end we understand this is his way of remembering" (Van der Kolk & Ducey, 1989).

It has become clear that the very nature of traumatic information processing determines the reenactment behavior. We must assume that as human beings, we are meant to function at our maximum level of integration and that any barrier to this integration will produce some innate compensatory mechanism that allows us to overcome it. Splitting traumatic memories and feelings off into nonverbal images and sensations is life-saving in the short-term, but prevents full integration in the long-term.

Based on what we know about the split between verbal and nonverbal thought, it may be that the most useful way of understanding traumatic reenactment is through the language of drama. Shakespeare told us that the whole world is our stage, and with behavioral reenactments we see this in action. We reenact our past everywhere - at home, at school, at the workplace, on the playground, in the streets. We cue each other to play roles in our own personal dramas, secretly hoping that someone will give us a different script, a different outcome to the drama, depending on how damaging our experiences have been. The cure is in the disease.

The only way that the nonverbal brain can "speak" is through behavior, since it has no words. If we look at reenactment behavior we can see that traumatized people are trying to repeatedly "tell their story" in very overt or highly disguised ways. If only

we could still interpret nonverbal messages, perhaps we could respond more adequately to this "call for help". For healing to occur, we must give words and meaning to our overwhelming experiences. In "Macbeth", Shakespeare urges us to "Give sorrow words; the grief that does not speak. But we cannot find the words by ourselves. That is the whole point - the traumatized person is cut off from language, deprived of the power of words, trapped in speechless terror.

We need the help, the words, the signals, of caring others, but to get their attention we must find some way to signal them about our distress in a language that has no words. This is the language of behavior, the language of the mime, of the stage. It is the language of symptoms, of pathology, of deviant behavior in all its forms. Unfortunately, we have largely lost the capacity for nonverbal interpretation, and so most of this “cries for help” fall on deaf ears. Instead, we judge, condemn, exclude and alienate the person who is behaving in an asocial, self-destructive, or antisocial way without hearing the meaning in the message. To counter these long standing habits, we need to develop systems of compassionate regard, translate the nonverbal message into a verbal understanding that can be shared, while still insisting on healthy change and behavior that is socialized, responsible, and nonviolent.

2.4.12 Trauma and the body

Victims of chronic trauma, abuse and neglect often suffer from a multitude of physical disorders not directly related to whatever injuries they have suffered. There is now a science of stress-related disorders that details how stress impacts negatively on the body in a number of ways, producing short-term and long-term physical consequences (Sarno, 1998). A recent study by the Center for Disease Control surveyed almost 14,000 adults in a health maintenance organization, asking participants about their adverse childhood experiences divided into categories that included physical, sexual and emotional abuse, witnessing violence against one's mother, living as a child with a household member who was either imprisoned, mentally ill, suicidal, or a substance abuser. There was a direct relationship between the number of categories of adverse childhood experience and adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

2.4.13 Victim to victimizer

When we understand the effects of trauma it is easier to grasp how someone could be victimized and turn away from the victim role and towards the victimizer role instead. A victim is both helpless and powerless, and as we have seen, helplessness is a noxious human experience. Human beings will do anything to avoid feeling powerless. If you have been victimized, one of the possible outcomes is to assume the power of the one who has hurt you by becoming someone who terrorizes and abuses others. Such behavior can reduce anxiety while providing a certain excitement and the combination of these two effects can become habit-forming. These effects can also be profoundly culturally influenced. The traditional definition of masculinity does not allow for helplessness - you cannot be a victim and be masculine. In contrast, the traditional definition of femininity not only allows for but encourages, powerlessness and therefore the open possibility of victimization. It should come as no surprise, therefore, that more men would accommodate to the victimizer role and women the victim role (Real, 1997).

2.4.14 Issues of meaning and spirituality

The experience of trauma shatters - often irrevocably some very basic assumptions about our world, our relationship to others, and our basic sense of identity and place in the world. A sense of meaning and purpose for being alive are shaken. Making sense out of violence, transcending its effects, and transforming the energy of violence into something powerfully good for oneself and the community describes what Judith Herman has called "a survivor mission" (1992). It is often a mission that encompasses the remainder of one's life. Confrontation with the spiritual, philosophical, and/or religious context - and conflicts - of human experience is impossible to avoid if recovery is to be assured.

2.4.15 Creating sanctuary

Creating Sanctuary refers to the process involved in creating safe environments that promote healing and sustain human growth, learning, and health (Bloom, 1997). One

fundamental attribute of Creating Sanctuary is changing the presenting question with which we verbally or implicitly confront another human being whose behavior we do not understand from "What's wrong with you?" to "What's happened to you?" Changing our position vis-a-vis other people in this way radically shifts our perspective on ourselves and others, moving us toward a position of compassion and understanding and away from blame and criticism. When people receive understanding from others it enables them to begin their way down the long road of understanding - and changing - themselves.

We have come to believe that in order to create safe, living-learning environments, any group of people must come to share the same basic assumptions, goals, and practice utilizing a shared language. A large part of the dilemmas currently facing us in all our communities is that we have not defined what - if anything we share in common. We have not yet hammered out agreements, resolved conflicts, or untangled contradictions about even the most fundamental rules of how we are supposed to behave towards each other, what is allowed and what is forbidden. Without such basic structure, we cannot expect that our problem solving will be effective - it is set on too unstable a ground.

The first and most essential assumption must be the human need for safety. Our definition of safety however includes not just physical safety, but psychological, social and moral safety as well. Psychological safety is the ability to be safe with one self. Social safety is the ability to be safe in groups and with other people. Moral safety involves the maintenance of a value system that does not contradict itself and is consistent with healthy human development as well as physical, psychological and social safety. An environment cannot be truly safe unless all of these levels of safety are addressed. As we can see all around us, a focus on physical safety alone results in us living in an armed fortress, paranoid and alienated from others.

Safety involves not just prohibitions against violence to others but also prohibitions against the short and long forms of self-destruction, i.e. suicide and substance abuse. In a connected community, the violence you do to yourself and your own body also affects me. Violence is violence even if it takes the form of cutting one's own wrists, or abusing one's own body in other ways. Sexism, racism, poverty, homelessness, and hate speech can all be seen as forms of injustice and violence against the heart and soul of a people and a community. The real challenge is how to establish and maintain

safety without invoking punitive, violent, and restrictive measures that add to the problem.

In the material above I have already drawn out some of the implications of trauma theory as they relate to what we now understand about the complex effects of trauma on the mind and body. We also assume that social influence is a powerful force in human organization and can be used for both positive and negative purposes. Any healthy human group will make an effort to maximize the positive aspects of social influence and group pressure and minimize the negative. Since every community organization must share assumptions, goals and practices, every group must make it a priority to create its own "constitution", establishing its mission, its goals, and the way it intends to go about achieving those goals. Since order and law is the basis of all civilization, a basic tenet of such a constitution must be nonviolence - and that tenet is not negotiable. No form of violence is acceptable, regardless of whether it is verbal, physical, sexual, social or economic. Violence must be viewed not as an individual problem, but symptoms of the breakdown of the social order and therefore a problem for the group. Therefore every act of violence must be analyzed, understood, and addressed as a problem of and for the entire community to resolve - nonviolently.

2.5 Secondary trauma theory

2.5.1 Background

To understand what secondary trauma dose we have to understand theory of McCann and Pearlman's (1990) Constructivist Self Development Theory "CSDT" served as the theoretical foundation for this study. The CSDT is a developmental interpersonal theory that provides an understanding of the psychological, interpersonal and adaptation effects that previous traumatic events have on the individual who counsels victims of trauma. McCann and Pearlman (1990) use the term "helper" to describe the person who assists traumatized individuals. In this study, the term "professional workers" will be used to describe the person who assists traumatized individuals.

2.5.2 The CSDT is based on the following assumptions

2.5.2.1 Constructivism

The underlying premise of the constructivist perspective is that the meaning that individuals attach to the previous traumatic events is related to how they experience that event. This is because individuals construct their own reality through developing cognitive structures known as schemas. These schemas include beliefs, assumptions and expectations of the self and the world. The CSDT suggests that the changes to helpers' cognitive schemas are pervasive (potentially affecting all areas of the helpers' life) and cumulative (potentially permanent because each traumatized client the professional workers encounters reinforces these changes) (McCann, 1990).

2.5.2.2 Individual differences

Every individual adapts differently to trauma. These differences include life experience, personal trauma history, personality and the meaning attached to trauma (Pearlman & Saakvitne, 1995).

2.5.2.3 Developmental perspective

The central premise of the development perspective is that individuals' early development shapes the way they experience and interact with the self and others. Trauma, for example childhood sexual abuse, arrests the individual's development (Pearlman & Saakvitne, 1995).

2.5.3 According to the CSDT there are five aspects of the self that are impacted by psychological trauma

Frame of reference refers to the individuals' framework for viewing themselves and the world. Frame of reference is important as it refers to how the individual perceives and interprets life experiences (Pearlman & Saakvitne, 1995). According to McCann and Pearlman (1990), "a meaningful frame of reference for human experience is a fundamental human need". Frame of reference encompasses individuals' world-view, identity and spirituality.

World-view refers to the helpers' beliefs about the world which includes attitudes about others, their worth, intentions and role in the individual's life (Pearlman & Saakvitne, 1995).

Identity reflects the individuals' inner experience of self which includes their personal story, relationship with themselves and their perception of themselves in relation to others (Pearlman & Saakvitne, 1995).

Spirituality refers to the meaning about themselves in the world. There are four components: orientation to the future and sense of meaning in life, awareness of all aspects of life, relation to the non-material existence and the connection with something beyond themselves, for example a god or a higher power (Pearlman & Saakvitne, 1995).

Self-capacities Refer to the "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive esteem" (Pearlman 1998:9; Pearlman & Saakvitne, 1995).
These self-capacities allow individuals to manage emotions, maintain interpersonal relationships and sustain positive feelings about themselves. When the professionals workers experiences vicarious traumatization, these self-capacities are disrupted and the professionals workers may experience loss of identity, interpersonal difficulties, difficulty in controlling negative emotion or self doubt in meeting significant others' needs (Trippany, White Kress & Wilcoxon, 2004).

Ego resources Ego resources are "inner faculties that the individual use to navigate the interpersonal world and meet his/her psychological needs" (Pearlman & Saakvitne

1995).

There are two sets of resources:

- resources important to the counseling process: intelligence, willpower and initiative, awareness of psychological needs, striving for personal growth
- Protecting oneself from harm: ability to conceive consequence, ability to set boundaries, ability to self-protect (Pearlman & Saakvitne, 1995).

Disruptions may promote perfectionism and the inability to be empathetic (Trippany, 2004).

Psychological needs and related schemas (in relation to self and others)

Cognitive manifestations of the psychological needs, namely, safety, trust, esteem, intimacy and control are known as schemas (McCann & Pearlman, 1990).

- Safety is the need to feel safe from harm by oneself and others (Pearlman & Saakvitne, 1995).
- Trust includes self trust and trust of others. The need to trust own perceptions and beliefs, as well as to depend on others (Pearlman & Saakvitne, 1995; Trippany, 2004).
- Esteem is the need to feel valued by oneself and to value others. Also the need to perceive others as worthy of respect (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).
- Intimacy is the professional workers "need to feel connected to oneself and others" (Pearlman & Saakvitne, 1995).
- Control is the professionals workers need to self-manage as well as to manage others in interpersonal situations (McCann & Pearlman, 1990).

The CSDT views the responses of the professionals workers to the clients' traumatic narratives as being shaped by the professionals workers own psychological needs (safety, trust, esteem, intimacy and control), cognitive schemas and by the characteristics of the situation. All individuals possess these five psychological need areas and appear to be very sensitive to psychological trauma. As individuals are unique beings, each need area is more or less salient for each individual, meaning that if the professional workers have disrupted safety needs, there will be an increased feeling of insecurity when working with trauma victims (Pearlman & Saakvitne,

1995).

Memory system Within the CSDT, traumatic memory is descriptive. Pearlman and Saakvitne (1995-a) identify five aspects of the memory:

- Verbal memory (cognitive narratives)
- Imagery (pictures in the mind)
- Affect (emotions experienced)
- Somatic memory (physical sensations)
- Interpersonal trauma (dynamics in current interpersonal relationships).

Each aspect of memory can represent a fragment of a previous traumatic event when a person experiences trauma. According to the CSDT, these fragments interfere with one's awareness if they are not therapeutically integrated (Trippany, 2004).

Trippany (2004) maintain that the memory of the traumatic narratives remains with the professional workers after the counseling session has ended. Some professional workers use defense mechanisms such as numbing, avoidance or denial to deal with vicarious trauma, which only offers temporary relief. Ortlepp (1998) states that some people alter their state of consciousness, enabling them to distance themselves from the state of unbearable arousal associated with trauma. In her study on emergency services' professionals, Hattingh (2001) found that some respondents were reluctant to admit that traumatic situations affected them, stating rather that they were used to coping with trauma. Hattingh alludes further to the profound psychic numbing that occurs in health care professionals who are exposed to extreme, longstanding or repeated trauma. Professional workers treating victims of trauma can experience intrusive thoughts, flashbacks and dreams that have no meaning. Imagery is related to the professionals workers psychological need area. These traumatic memories can become permanently entrenched in the professional workers memory system (McCann & Pearlman, 1990).

2.6 Theories of Anxiety

In this section we will present some of the theories that explained anxiety state and its

scientific approaches and how people affected by this disorder. The researcher will talk about four core theories of anxiety from which genetic, psychodynamic, learned and biochemical theories.

2.6.1 Genetic theory

Isaac Marks (1986) has provided an elegant summary of the genetics of fear and anxiety disorders (Marks, 1986):

From protozoa to mammals, organisms have been selectively bred for genetic differences in defensive behavior which are accompanied by differences in brain and other biological functions. Studies of twins .indicate some genetic control of normal human fear from infancy onwards, of anxiety as a symptom and as a syndrome, and of phobic and obsessive-compulsive phenomena. Anxiety disorders are more common among the relatives of affected propounds than of controls, especially among female and first-degree relatives; alcoholism and secondary depression. May also be over represented. Familial influences have been found for panic disorder, agoraphobia, and obsessive-compulsive problems. Panic disorder in depressed propounds increases the risk to their relatives of phobia as well as of panic disorder, major depression, and alcoholism. The strongest family history of all anxiety disorders is seen in blood injury phobia; even though it can be successfully treated by exposure, its roots may lie in a genetically determined specific autonomic susceptibility. Some genetic effects can be modified by environmental means.

2.6.2 Psychodynamic theory

Although Freud at first proposed a physiological basis for anxiety, he later concluded that anxiety serves as a signal to the ego of the emergence of an unconscious conflict or impulse. His theory led to the development of psychoanalysis, used to study and treat emotional disorders. According to psychoanalytic theory, anxiety is seen as an emotion of the ego (the part of our mental apparatus that balances the impulses and demands of our childlike id, the stern and punitive controls of our parent like superego, and external reality). Anxiety is also seen as the key indication of hidden psychological conflict.

2.6.3 Learned behavioral theory

Behavioral therapists hold that anxiety is a learned response to some noxious situation

or stimulus. When a situation or stimulus provokes anxiety in a person, the person learns to reduce the anxiety by avoiding the situations that provoke it. Generalized anxiety disorder may result from the unpredictability of positive and negative reinforcement-the person is uncertain when and if avoidance behaviors will be effective in reducing anxiety.

It is also possible to develop anxiety in response to generally positive or neutral stimuli if these are associated with a noxious or aversive stimulus. This conditioning process is held to be responsible for the avoidance of neutral or benign situations in which distressing anxiety (such as panic) has occurred. Pairing of a recurrent anxiety inducing thought (such as "contamination") with a compulsive behavior (such as hand washing) that reduces anxiety is thought to explain the development of obsessive-compulsive disorder.

2.6.4 Biochemical theory

When compared with normal controls, patients with anxiety disorders have significantly different physiological functioning (eg, higher heart rate, higher blood lactate levels, and greater oxygen debt during moderate exercise). Patients with panic disorders are more sensitive to a number of substances (eg, caffeine, lactate, isoproterenol, epinephrine, yohimbine, and piperoxan). Many of these substances increase activity of the locusceruleus, the midbrain nucleus that supplies about 70% of the norepinephrine-releasing neurons in the central nervous system. Given these substances human subjects report increased anxiety and monkeys demonstrate fear behaviors similar to those they show when placed in a confrontational setting. Electrical stimulation of the locus ceruleus in monkeys produces a similar fear response, whereas its ablation reduces fear behaviors. Medications that inhibit functioning of the locus ceruleus also reduce fear responses in monkeys and anxiety in humans with anxiety disorders as well as in controls. Although u2-agonists and adrenergic receptor blockers have been shown to have some ant anxiety properties, the selective serotonin reuptake inhibitors, monoamine oxidize inhibitor antidepressants, and benzodiazepine drugs, which down-regulate function of the locus ceruleus (nor- epinephrine), are the most useful clinically.

The benzodiazepines have a second putative mode of action in that they potentiate yaminobutyric acid (GABA), a widely distributed inhibitory neurotransmitter. Discovery of benzodiazepine receptors in the central nervous system led to a search

for endogenous benzodiazepines, and these have now been found.

Abnormal neurotransmission of serotonin is thought to explain part of the path physiology of obsessive-compulsive disorder, and potent serotonin uptake inhibitors are the most predictably effective medications for this disorder.

The apparent biochemical basis of every behavior, thought, and feeling does not dictate that biochemical abnormalities must be treated with chemicals-brain chemistry can also be changed by behavioral, psychological, and surgical interventions.

2.6 Studies review

2.6.1 Background

In this chapter secondary traumatic will be clarified and other concepts, namely burnout, compassion fatigue/ vicarious traumatization, counter-transference, posttraumatic stress disorder and traumatic states, will be defined to give clarity on their conceptualization within trauma work. The differences and similarities between these concepts and secondary trauma will be alluded to.

2.6.2 Studies concern with secondary trauma

In study of secondary traumatic stress to describe the development and validation of the secondary traumatic stress scale (STSS), a 17-item instrument designed to measure intrusion, avoidance, and arousal symptoms associated with indirect exposure to previous traumatic events via one's professional relationships with traumatized clients. Method: A sample of 287 licensed social workers completed a mailed survey containing the STSS and other relevant survey items. Results: Evidence was found for reliability, convergent and discriminate validity, and factorial validity. Conclusions: The STSS fills a need for reliable and valid instruments specifically designed to measure the negative effects of social work practice with traumatized populations. The instrument may be used to undertake empirical investigation into the prevention and amelioration of secondary traumatic stress among social work practitioners (Bride, Robinson and Figley, 1999).

In study of secondary traumatic stress, secondary traumatic stress disorder or compassion stress. Compassion fatigue is the preoccupation with the individual's trauma, which includes re-experiencing the event, avoiding/numbing the event and hyper arousal. The onset of compassion fatigue is acute and sudden. Although both compassion fatigue and vicarious trauma are both associated with the "cost of caring", these constructs are conceptually different (Figley, 1995). While compassion fatigue focuses on symptoms constellation, vicarious trauma emphasizes the role of meaning and adaptation to trauma work (Annscheutz, 1999). Thomas and Wilson (2004) describe a lack of strength, exhaustion, lack of energy and vitality as compassion fatigue (Thompson, 2003).

In study of Relationships between secondary traumatic stress (STS) symptoms and therapist characteristics and assignment variables were examined for 81 disaster mental health (DMH) workers who responded to the terrorist attacks of September 11,

2001. Higher STS was associated with therapist variables of heavier prior trauma caseload, less professionals experience, youth, and therapist's discussion of his or her own trauma or trauma work in his or her own therapy. Therapist gender and personal trauma history were not significantly related to STS. Assignment variables associated with higher STS included longer length of assignment and more time spent with child clients, firefighters (who suffered great losses in the tragedy), or clients who discussed morbid material. Recommendations for practice include informing DMH recruits of therapist risk factors and assigning at-risk DMH workers to lower-risk assignments (Creamer and Liddle et al 2005).

This study examines secondary traumatization among 708 partners and 332 parents of Dutch peacekeepers (i.e., personnel who participated in military actions implemented by international organizations such as the United Nations). Partners or parents of peacekeepers with 4 levels of posttraumatic stress symptoms were compared on posttraumatic stress, health problems, the quality of the marital relationship, and social support. In comparison with partners of peacekeepers without posttraumatic stress disorder (PTSD) symptoms, partners of peacekeepers with PTSD symptoms reported more sleeping and somatic problems, reported more negative social support, and judged the marital relationship as less favorable. No significant differences were found for parents. Thus, peacekeepers' stress reactions were related to various problems of their partners. A systemic approach to the treatment of persons with PTSD appears appropriate (Dirkzwager and Bramsen, 2005).

In study of secondary traumatization of wives of former prisoners of war (POWs) as manifested in posttraumatic stress disorder (PTSD) symptoms, additional psychiatric symptoms, and marital adjustment. In addition, it assessed the role of several contributors to the wives' secondary traumatization: the husband's PTSD, the level of his verbal and physical aggression, and the wife's level of self-disclosure. Methods The study compared three groups of Israeli wives: wives of POWs with PTSD (N=18), wives of POWs without PTSD, (N=64), and a control group of wives of veterans without PTSD (N=72). Results the highest level of distress in all measures was endorsed by the wives of POWs with PTSD. Moreover, in addition to husband's PTSD and captivity, both the man's aggression and the wife's self disclosure played a role in the wife's level of distress. Conclusions The findings show that the husbands'

PTSD was more strongly associated with the wives' secondary traumatization than their captivity (Dekel and Solomon, 2006).

In study of Health outcomes and, in particular, patient health outcomes have become a driving force within health-care delivery. Little emphasis has been placed on the potential health consequences for professional worker providing care and caring within the health-care system. Compassion fatigue (or secondary traumatic stress) has emerged as a natural consequence of caring for clients who are in pain, suffering or traumatized. This paper sheds light on how nursing work might impact the health of professional workers by exploring the concept of compassion fatigue. Limitations of current instruments to measure compassion fatigue are highlighted, and suggestions for future direction are presented (Sabo, 2006).

2.6.3 Studies concern with vicarious trauma

In study of vicarious traumatization define as a process through which the professionals workers "inner experience about the self and the world is negatively transformed as a result of empathetic engagement with trauma survivors". Through exposure to their clients' accounts of previous traumatic events and the realities of people's intentional cruelty to one another, and the experience of reliving terror, grief and yearning, the professional workers is vulnerable through empathic engagement as both witness and participant in these traumatic reenactments. These effects are cumulative and may be permanent (Pearlman & Saakvitne, 1995). According to Dane and Chachkes (2001), vicarious traumatization develops over time and affects a person's professionals and social identity. However, not everyone who is vicariously exposed to traumatic narratives develops symptoms of vicarious traumatization (Pearlman and Saakvitne, 1995).

In study of vicarious traumatization is a relatively new concept and possibly accounts for the international dearth of literature; however, there is an increasing number of literature review articles highlighting the topic. Further, there are a growing number of research studies investigating vicarious traumatization. Empirical studies still remain in a primitive state; however, it is an active area for ongoing research as it is introduced into additional groups such as social work (Iliffe and Steed, 2000).

In study of vicarious trauma (VT) and secondary traumatic stress (STS) or compassion fatigue both describe effects of working with traumatized persons on therapists. Despite conceptual similarities, their emphases differ: cognitive schemas vs. posttraumatic symptoms and burnout, respectively. The TSI Belief Scale (TSI-BSL) measures VT, the Compassion Fatigue Self-Test (CFST) for Psychotherapists measures STS. Neither has substantial psychometric evidence yet, nor has their association been studied. Results for 99 sexual assault and domestic violence counselors show concurrent validity between TSI-BSL and CFST. Moderate convergence with burnout but useful discrimination, strong convergence with general distress, and but adequate independent shared variance. Counselors with interpersonal trauma histories scored higher on CFST, but not TSI-BSL or burnout, consistent with the CFST's emphasis on trauma symptomsatology (Jenkins and Baird, 2002).

In study of vicarious traumatization it has been suggested that a unique feature of some mental health practitioners' work is exposure through their role as therapists to clients' descriptions of and reactions to trauma, and that these experiences may actually indirectly cause distress and traumatization to the therapist. This proposed phenomenon has been termed ''vicarious traumatization'' (VT) and is the focus of the current review. The concept of VT, together with other related concepts such as ''burnout,'' ''compassion fatigue,'' ''secondary traumatic stress'' (STS), and ''work stress'' are appraised. Psychological mechanisms that might be theoretically involved in VT are considered. The measurement of VT is reviewed alongside the limited research evidence supporting its existence. Factors such as direct trauma exposure and the personal attributes of mental health workers, which have been suggested to be associated with VT, are also assessed. It is concluded that the evidence to support the existence of VT is meager and inconsistent. Future research needs to be directed at distinguishing VT from other sources of distress arising within the workplace. Finally, the organizational relevance of VT and its possible implications for the management of mental health workers are critically appraised (Sabin-Farrell and Turpin, 2003).

In study of Symptoms of vicarious trauma, coping strategies, and prevention suggestions were investigated with 105 judges. Participants completed a self-report measure developed for this study. The majority of judges (63%) reported one or more symptoms that they identified as work related vicarious trauma experiences. Female

judges reported more symptoms, as did judges with seven or more years of experience. In addition, female judges were more likely to report internalizing difficulties, while judges with more experience reported higher levels of externalizing/hostility symptoms. Coping and prevention strategies were multi-domain (i.e., personal, professionals, and societal) and underscored the need for greater awareness and support for judges (Jaffe, Crooks, Dunford-Jackson, and Town, 2003).

In study of Disaster and trauma workers often disregard their own reactions and needs when focusing on caring for those directly exposed to previous traumatic events. This article discusses the concept of vicarious traumatization, a form of post-traumatic stress response sometimes experienced by those who indirectly are exposed to previous traumatic events. It includes an examination of how vicarious trauma reactions are experienced across different professions, and suggestions on how to limit or prevent vicarious traumatization. The authors review self-care strategies as well as training and organizational considerations that may be beneficial for individuals and organizations to address (Palm, polusny, and follette, 2004).

In study of Vicarious traumatization is a significant concern for counselors providing services to traumatized clients. Counselors' cognizance of potential changes in their beliefs about self, others, and the world may have a preventative function regarding VT. This awareness can aid counselors in protecting themselves against the consequential effects of helping those with traumatic histories. An awareness of personal reactions to VT may allow counselors to implement self care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties. In addition, it is important that supervisors and administrators overseeing counselors working with trauma survivors consider the impact that VT may have on counselors and take an active preventative role. Supervisors have a responsibility to use their knowledge about VT to prevent counselor VT and to facilitate counselor mental health through providing a supportive and VT-preventative environment. Encouraging peer support groups, educating counselors on the impact of client traumas on counselors, diversifying counselor caseloads, encouraging counselor respite and relaxation, and encouraging counselors' sense of spirituality and wellness are several means of providing support for at-risk counselors. Professional counselors

have much strength and resources that are used to help traumatized clients applying these resources to themselves, as a means of preventing VT, will surely facilitate their own wellness (Trippany, Kress, and Wilcoxon, 2004).

This study compared vicarious trauma in a random sample of male and female clinicians who treat survivors (n=95) and those who treat offenders (n=252).A national survey was conducted with members of the Association for the Treatment of Sexual Abusers (ATSA) and the American Professionals Society on the Abuse of Children (APSAC). These data were used to test the relative contribution of variables theorized to contribute to two vicarious trauma effects (avoidance and intrusions) using the Impact of Event Scale. The sample reported high levels of avoidance and intrusions. Variables associated with vicarious trauma differed based on client population served. Sequential regression analyses were used to examine theoretically derived variables. Implications for practice and further research are discussed. (Way and Vandeusen, 2004)

In study of Post-traumatic stress through indirect exposure to trauma can mimic the psychological experiences of direct victims. This is referred to as vicarious traumatization, an impairing condition that largely goes undetected in the general population. This study sought to describe this condition and predict those who may be at risk of developing this type of post-traumatic stress. One hundred and fifteen participants from south-east New South Wales (NSW) in Australia who had not experienced any direct exposure, loss or injury from the 2001–2002 NSW bushfires were interviewed using the Vicarious Traumatization Questionnaire, Impact of Events Scale and Coping Strategies Indicator. Results indicated that specific prey-event, post-event and pre-event characteristics were able to predict at least 75 per cent of those who experienced vicarious traumatization resulting from the 2001–2002 NSW bushfires. This study was able to identify and describe vicarious traumatization in a sample of the general population. The importance of these results and the issues for further research are discussed (Byrne and Lerias, 2006).

In study of vicarious traumatization, descriptive, and empirical literature examining vicarious traumatization in therapists treating sexual offenders. Vicarious traumatization in sexual offender therapists is described, including an examination of the relationships between vicarious traumatization and client, therapist, and setting

and therapy characteristics. Special attention is given to those unique factors that contribute to the development of vicarious traumatization in this group, as well as consideration of why therapists treating offenders or victims may differ in their experience and development of vicarious traumatization. Evidence from the research reviewed suggests that sexual offender therapists do experience symptoms of vicarious traumatization. Factors most strongly associated with the development of vicarious traumatization in sexual offender therapists include professionals experience, treatment setting, and coping strategies employed by the therapists. Implications and recommendations for professionals and policymakers are discussed (Moulden and Firestone, 2007).

In study of Vicarious traumatization is now a well-known entity and may have negative influences on those that are involved in rescue efforts in any disaster or previous traumatic events. Healthcare workers work with trauma survivors and witness an immense array of gruesome and ghastly images. This work has the potential to cause those engaged in rescue efforts to become affected subconsciously. Job-related stress may cause psychological symptoms in care providers who provide support and listen to the survivors' account of trauma. A therapist working in disaster situations may become a victim of psychological anguish—undermining their physical and mental well-being as well as their profession, adversely affecting their traumatized patients, and leading to a counter-productive therapist-survivor relationship. This significant theme of secondary trauma must be recognized in relief workers at early stages and must be addressed at an individual as well as organizational level. The key may lie in turning to social supports, adapting positive coping mechanisms, and subsequently seeking mental health consultation. Further research is required in this area to determine the best resolution (Bilal, Rana, and Rahim, 2007).

In study of vicarious trauma explored vicarious trauma among therapist trainees in relation to history of trauma, experience level, trauma-specific training, and defense style. Students in graduate clinical and counseling psychology training programs (N _ 129) completed the Trauma Symptoms Inventory, Defense Style Questionnaire, and an experience questionnaire. Results indicated trauma symptoms were significantly associated with defense style, which appeared to moderate personal trauma history

and experience level. Trauma-specific training was also independently related to trauma symptoms. Notably, over half the sample reported a self-sacrificing defense style, which was a risk factor for vicarious trauma. Training implications of the findings are discussed (Adams, 2008).

2.6.4 Studies concern with burnout

In study of burnout define as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur amongst individuals who work with people". According to Bell, Kulkarni and Dalton (2003), vicarious trauma may present with emotional exhaustion, depersonalization and reduced personal accomplishment. These effects are unique to trauma work, however. Burnout is similar to vicarious trauma as it results from exposure to clients who are emotionally charged through challenging jobs which results in the professional workers being unable to render an effective service (Jenkins & Baird 2002). Although burnout is not limited to persons working with the traumatized, it can occur as a result of repeated exposure to people's traumatic experiences (Maslach, jacksn, and leitert, 1996).

In study of Counter-transference is "an awareness and legitimate recognition of our emotional reactions to events which increase the repertoire of data we have to understand that are stirred up within us when we are interacting with others". Figley (1999) defines counter-transference as "the process of over-identifying with the client". Counter transference can also be described as the affective and physical responses of the professionals workers to the client and the professionals workers conscious and unconscious defenses against these affects (Pearlman & Saakvitne 1995). Counter-transference responses can precipitate vicarious traumatization when self-awareness is decreased by the therapist's overwhelming feelings during a therapeutic relationship. Counter-transference is specific to a therapeutic relationship while vicarious trauma is cumulative and manifests through empathic engagement with traumatized clients (Kapur, 1999).

In study of burnout maintain that burnout is a feeling related to difficult, that is, chronic and complex, client population, whereas vicarious traumatization reactions are related to specific client traumatic experiences. While burnout is related to workplace conditions, vicarious trauma focuses on the process of empathic

engagement with traumatized people (Jenkins & Baird, 2002). Annscheutz (1999) is of the opinion that people most vulnerable to burnout are those who are unable to confide in others. Professionals workers, like persons from other professions (e.g., doctors), are bound by the ethical principle of confidentiality which prohibits them from discussing the narratives of overwhelming horror and cruelty experienced by their traumatized clients, with others. Unaddressed vicarious trauma sets the stage for burnout, resulting in professional workers leaving the mental health service (Trippany, kress, and wilcoxon, 2004).

2.6.5 Studies concern with compassion fatigue

In study of trauma has highlighted the potential for interventions to exacerbate the trauma reaction. The general rule of 'do no harm' should apply not only to professionals but volunteers alike. This paper reviews the literature on brief interventions for people who have been exposed to trauma at varying levels. The parameters of a single session intervention and the skill of volunteers are considered in recommending a protocol for intervention. We propose an 'orienting' framework to intervention that emphasizes support, normalization and self help strategies (Phipps and Byrne, 2003).

In study of compassion fatigue focused on caring professionals and their emotional exhaustion from working with traumatized clients, referred to as Compassion Fatigue (CF). The present study had two goals: 1) to assess the psychometric properties of a CF scale, and 2) to examine the scale's predictive power in a multivariate model. The data come from a survey of social workers living in New York City following the September 11 terrorist attacks on the World Trade Center. Factor analyses indicated that the CF scale measured multiple dimensions. After eliminating overlapping items, the scale measured two key underlying dimensions – Secondary Trauma and Job Burnout. In a multivariate model, Secondary Trauma and Burnout were related to psychological distress, even after controlling for other risk factors. We discuss the results in light of increasing the ability of professional caregivers to meet the emotional needs of their clients within a stressful environment without experiencing CF (Adams, 2004).

In study of Disaster and trauma workers often disregard their own reactions and needs when focusing on caring for those directly exposed to previous traumatic events. This article discusses the concept of vicarious traumatization, a form of post-traumatic stress response sometimes experienced by those who indirectly are exposed to previous traumatic events. It includes an examination of how vicarious trauma reactions are experienced across different professions, and suggestions on how to limit or prevent vicarious traumatization. The authors review self-care strategies as well as training and organizational considerations that may be beneficial for individuals and organizations to address (Palm, Polusny and Follette, 2004).

In study of Health outcomes and, in particular, patient health outcomes have become a driving force within health-care delivery. Little emphasis has been placed on the potential health consequences for professional workers providing care and caring within the health-care system. Compassion fatigue (or secondary traumatic stress) has emerged as a natural consequence of caring for clients who are in pain, suffering or traumatized. This paper sheds light on how nursing work might impact the health of professional workers by exploring the concept of compassion fatigue. Limitations of current instruments to measure compassion fatigue are highlighted, and suggestions for future direction are presented (Sabo, 2005).

In study of the prevalence of compassion fatigue among cancer-care providers, instruments used to detect it and means of prevention and treatment. Conclusions were limited by an ambiguous definition of compassion fatigue that fails to adequately differentiate it from related constructs (e.g. burnout, secondary traumatic stress) and the modest number of cancer-related studies found. However, evidence suggests that compassion fatigue takes a toll not only on cancer-care providers but also on the workplace. These findings highlight the need to understand more clearly the link between the empathic sensitivity of healthcare professionals and their vulnerability to compassion fatigue (Naiiar, 2009).

In study of burnout, compassion fatigue, secondary trauma symptoms, and compassion satisfaction in relation to experienced therapists' perceptions of the working alliance. Participants, 106 specialists in the treatment of clients who commit sexual abuse, completed the Working Alliance Inventory—Short Form in relation to 1

of their male clients; the Professionals Quality of Life Scale—revised which assesses 3 components of work-related adjustment; and the Impact of Events Scale measure of secondary trauma. Results of the hierarchical regression analyses showed that perceived alliances were strongest for therapists who had been working relatively longer in this specific field. When the 4 work-related experiences were added to the demographic characteristics, compassion satisfaction was the only unique predictor of alliance ratings. Descriptive analyses showed low mean scores on secondary trauma symptoms and compassion fatigue and generally high levels of compassion satisfaction (Sheehy, Carmel and Friedlander, 2009).

This study examined the impact of routine occupational exposure to traumatic aspects of child illness, injury, and medical treatment upon care providers working within a children's hospital. Three hundred fourteen providers completed a demographic data sheet and four questionnaires. Results suggested overall that the level of Compassion Fatigue in this sample was similar to a trauma workers comparison group. In addition, 39% of the sample was at moderately to extremely high risk for Compassion Fatigue, and 21% was at moderate to high risk for Burnout. Burnout and Compassion Fatigue were related to type of profession and length of employment. Various dimensions of empathy were related to both Burnout and Compassion Fatigue. Regression analyses indicated that years in direct care and greater blurring of caregiver boundaries were predictive of greater Burnout and Compassion Fatigue. There is a need to further refine the assessment of occupational exposure to potential traumatic aspects of care within pediatric hospital settings and link assessment to prevention and intervention efforts (Meltzer and Zelikovsky, 2009).

2.6.6 Studies concern with Post-traumatic stress

In this study, a group of trauma therapists (N =100) working with torture survivors was investigated with respect to the extent to which they advocated and practiced working through previous traumatic events as well as levels of symptomatology

including compassion fatigue, burnout, and distress. Results showed that a combination of high advocacy and low degree of working through previous traumatic events was related to high symptomatology. Therapists with this combination showed more compassion fatigue, burnout, and distress than therapists who advocated and practiced working through previous traumatic events, as well as therapists who neither advocated nor practiced it. Results are discussed with respect to the pathogenic role of fear avoidance in therapists (Deighton, Gurris and Traue, 2007).

In study of Post-traumatic stress, the purpose of this study is to investigate the prevalence of STS in emergency professional workers. Methods: Exploratory comparative design, with 67 emergency professional workers from three general community hospitals in California. Survey instruments included a demographic tool and the STS Survey (STSS). Results: Professionals workers were most likely to have Arousal symptoms (irritability reported by 54% of professionals workers), followed by Avoidance symptoms (avoidance of patients 52%), and Intrusion symptoms (intrusive thoughts about patients 46%). The majority of professional workers (85%) reported at least one symptom in the past week. Utilizing Bride's algorithm to identify STS, 15% of professional workers met no criteria, while 33% met all. Professional workers participation in stress management activities was associated with less prevalence of STS symptoms (Dominguez-Gomez, 2009).

Chapter Three

Methodology

Chapter Three

Methodology

3.1 Introduction

This chapter describes the study design and methodology used in the study, including population, data collection, validity and reliability, and ethical considerations. The overall aim of the study was to explore and describe the effects of secondary trauma experienced by health professionals working at emergency departments in the Gaza Strip

3.2 Study design

In this study, the study approach was descriptive analytic design in order to understand the phenomenon under investigation. The study was an applied study because the knowledge generated could influence the support, training and supervision of health professionals working at emergency departments who assist victims of trauma.

3.3 Study population

The study population for this study was all male and female, doctors and nurses working at emergency departments, from this hospitals Beit Hanoon Hospital, Kamal Odwan Hospital, Al Shifa Medical Complex, Al Aqsa Martys Hospital, Nasser Medical Complex, European Gaza Hospital, and Abu Yousef Al-Najjar Hospital. The study population onsisted of 252 professional workers 221(87.6%) males and 31(12.4%) females. 90(35.8%) doctors and 162(64.2%) nurses.

3.4 Study sample

The study sample included all the doctors and nurses working at emergency departments in Gaza strip from previously mentioned hospitals and had met the inclusion criteria. The study consisted of 214 professional workers 193(90.2%) males and 21(9.8%) females. 78(36.4%) doctors, and 136(63.6%) nurses.

3.5 Period of the study

The study was performed in the second semester of the scholastic year 2010. This will ensure that data will be available about the health professionals working in emergency departments. The duration of study was approximately 3 months.

3.6 Eligibility criteria

3.6.1 Inclusion and exclusion criteria

For the purposes of this study, the participants had to :

- Be a registered health professionals working at emergency departments with an additional qualification .
- Be employed on a full-time scale in emergency departments .
- Be directly involved in treating victims of trauma.
- Work at emergency departments in any of the Gaza strip hospital.
- Should not be a volunteer.
- Should not be a student.

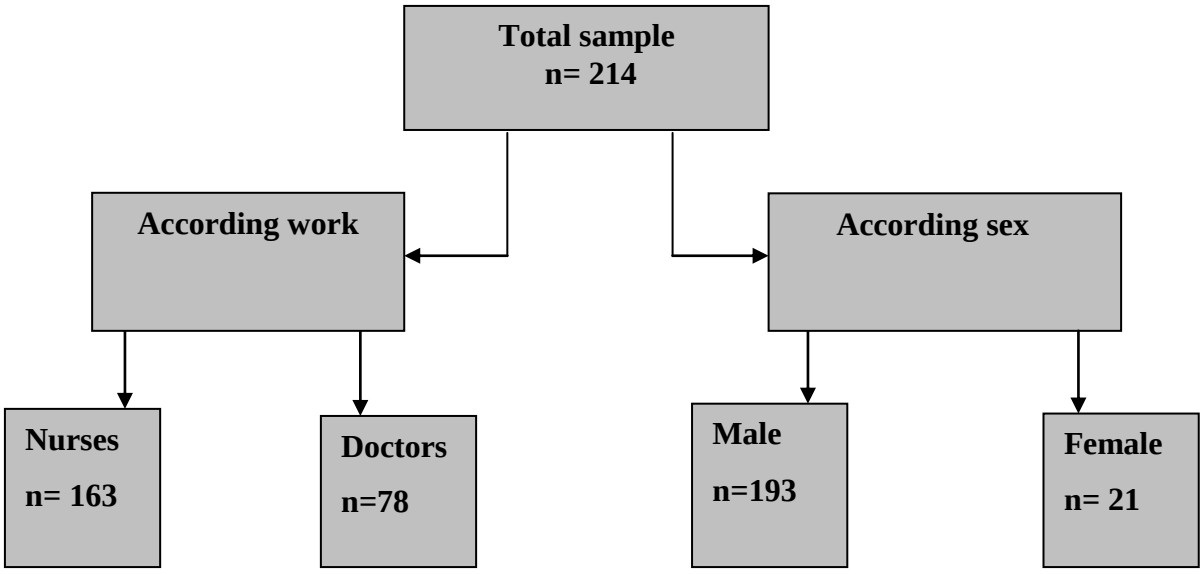


Figure (3.1): distribution the study sample according to sex and type of work

3.7 Ethical considerations

The ethical consideration and procedures are very important conditions in applying the research or performing any medical procedures, all of the ethical procedures have

to be followed perfectly without ignoring any of them, some of these important ethical procedures are:

- An official letter of approval to conduct the study has been obtained from the Human Resource Development in the Ministry of Health, which allow the researcher to carry out the study directly after that day (Annex 5)
- An official letter has been obtained from the General Administration of Hospitals in order to conduct the study in governmental hospitals and facilitate the process of data collection.
- Every subject in the study has received have an explanatory letter about the study, the researcher explained to all professionals worker that filling the questionnaire is optional and also emphasized confidentiality. Also ethical concept, respect for trust, and respect for people have been considered.

3.8 Data-collection instrument

In this study, the researcher collected using standardized questionnaire. According to Polit and Beck (2004) described the questionnaire as "a written formal schedule that respondents complete themselves The studier also devised questions relating to biographical data, personal trauma history, workplace experiences and support systems to fulfill the study questions and objectives .The questionnaire consist from four dimensions the socio-demographic status questioner, war on Gaza previous traumatic events checklist, secondary trauma check list, and Hamilton Anxiety Scale.

3.8.1 Socio-demographic status (developed by the researcher)

This was gathered from the study sample by questionnaire includes sex, age, place of residence, type of work, education level, social status, hospitals, and experiences (Annex 3).

3.8.2 Secondary trauma stress scale check list

As used in the present study, the final version of the secondary trauma check list is a 17 items, pencil-and-paper, designed to assess the frequency of intrusion, avoidance,

and arousal symptoms associated with secondary trauma. Respondents were instructed to read each item and indicate how frequently the item was true for them in the past days using a four choice format ranging from 1 (never) to 4 (very often). The secondary trauma check list was comprised of three subscales: Intrusion (items 2, 3, 6, 10, 13), avoidance (items 1, 5, 7, 9, 12, 14, 17), and arousal (items 4, 8, 11, 15, 16). Scores for the full STSS (all items) and each subscale are obtained by summing the items assigned to each (Annex 2).

Diagnostic Criteria: diagnostic criteria, consequently, study participants who reported at least 1 intrusion symptoms, at least 3 symptoms of avoidance, and at least 2 arousal symptoms meet for STSS (Bride, Robinson, and Figley, 1999).

3.8.3 Hamilton anxiety scale

Anxiety attacks defined by the Hamilton Anxiety Scale attack are defined by a discrete period apprehension or fear and at least four of the following symptoms: (Annex 1)

1. Dyspnea
2. Palpitations
3. Chest pain or discomfort
4. Choking or smothering sensations
5. Dizziness, vertigo, feeling unsteady
6. Feelings of unreality
7. Paresthesias
8. Hot and cold hushes
9. Sweating
10. Faintness
11. Trembling or shaking
12. Fear of dying, going crazy or doing something uncontrolled
13. Difficulties in concentration and memory
14. Depressed mood
15. General somatic symptoms (muscular)
16. General somatic symptoms (sensory)
17. Cardiovascular symptoms

3.9 Reliability

3.9.1 Reliability for secondary trauma check list

- **Split half method**

The researcher calculated the reliability of the **Secondary trauma** Checklist by using split half method (part I = 8 items & part2 = 9 items); where the person's correlation coefficient was (R I = 0.65) and by using the Spearman-Brawn equation to modify the length of the scale and the reliability coefficient was (R2 = 0.70).

- **Cronbach's alpha equation**

The researcher estimated the reliability of the Secondary trauma Checklist by using the equation of Cronbach's alpha (No. of items = 17); where the value of alpha = (0.859). Then secondary trauma Checklist measurement device is valid and reliable .

3.9.2 Reliability for Hamilton anxiety scale

- **Split half method**

The researcher calculated the reliability of the Hamilton anxiety checklist by using split half method (part I = 7 items & part2 = 7 items); where the Pearson's correlation coefficient was (R I = 0.63) and by using the Spearman-Brawn equation to modifying the length of the scale the reliability coefficient was (R2 = 0.74).

- **Cronbach's alpha equation**

The researcher estimated the validity of the Hamilton anxiety by using the equation of Cronbach's alpha (No. of items = 14); where the value of alpha= (0.859). Then Hamilton anxiety scale is valid and reliable.

3.10 Advantages of questionnaires

Questionnaires are less costly and require less time and energy to administer than interviews. As complete anonymity is possible, participants are more likely to provide honest answers. The format of the questionnaire is standard, therefore questions are consistent and there is less opportunity for interviewer bias.

3.11 Data entry and statistical analysis

The collected data have been processed and analyzed under the supervision of the academic supervisor and the statisticians. Data was entered by the statistical program

(SPSS 16 evaluation version) computer program for the data entry and analysis, this statistical program has a variety of options that is optimal for use in thus studies. Were data can be entered, labeled, coded and recorded as different variables, and tested in many kinds of statistical tests that are available in this program; including, differences between sex and age and variables were analyzed using independent samples t-tests. For differences between more than two groups One-way ANOVA test was used.

Chapter Four

Results

Chapter Four

Results

In this chapter the researcher will present the main findings of the study, including the characteristics of the sample, the type of previous traumatic events, the effect of secondary tramatization, the relationship between secondary trauma and socio-demographics, and the differences between secondary trauma and years of experience for health professionals working at emergency departments on their mental health (Anxiety).

4.1 Characteristics of the sample

The sample distribution according to socio-demographic variables such as age, sex type of professionals work, level of education, place of resident, social status, and hospitals.

The following table (4.1) shows the number and percent of workers according to sex, the table shows that of the total sample 214 the males were 193, and the females were 21 professionals worker. The number and percent of workers according to age group. Where the largest age group 20-29 years was 110(51.4%) professional workers, and only 4 workers where in the age group 50-60 years. The number and percent of workers according to social status from results of the study showed that 167 professional workers are married, 44 single, 3 widowers and no divorced. The number and percent of workers according to place of residence in the five governorates Gaza strip. There is almost an even distribution. From results of the study shows of total sample (214), North Gaza 45(21%), Gaza city 47(22%), Middle zone 35(16.4%), Khan-Younis 55(25.7%), and Rafah 32(15%).

The following table shows the number and percent of workers according to type of professional workers. From results of the study shows of total sample (214), doctors 78 (36.4%), and nurses 136 (63.6%). The number and percent of workers according to

experience. From results of the study shows of total sample (214), where 70.1% (150) have had less than 5 years of experience, from 6-15years 58(27.1%), and 2.8% (16) have had more than 6 years. The the number and percent of workers according to education level from results of the study the sample consisted of 12(5.6%) Practical nurse degrees, 55(25.7%) Diploma degrees, 112(52.3%) baccalaureate degrees, 14(6.5%) Master degrees, only one (0.5%) Ph.D. degrees, and 20(9.3%) Medical specialist degrees. The number and percent of workers according to hospital from results of the study which is consisted of 214 professional workers, 24(11.2%) Beit Hanoon Hospital, 24(12.5%) Kamal Odwan Hospital, 42(19.6%) Al Shifa Medical Complex, 26(12.1%) Al Aqsa Martys Hospital, 30(14%) Nasser Medical Complex, 38(17.8%) European Gaza Hospital, and 27(12.6%) Abu Yousf Al-Najjar Hospital.

Table (4.1) Samples distribution according to socio-demographic

Socio-demographic	No.	%

Sex		
Male	193	90.2
Female	21	9.8
Age		
20-29	110	51.4
30-39	71	33.2
40-49	29	13.6
50-60	4	1.9
Social status		
Single	44	20.6
Married	167	78
Widower	3	1.4
Divorce	0	0
Place of Resident		
North Gaza	45	21.0
Gaza	47	22.0
Middle	35	16.4
Khan Younis	55	25.7
Rafah	32	15.0
Type of professional		
Doctors	78	36.4
Nurses	136	63.6
Working Experience		
5 years less than	150	70.1
6-15 years	58	27.1
16 years MORE	6	2.8
Education al Level		
Practical nurse degrees	12	5.6
Diploma degrees	55	25.7
Baccalaureate degrees	112	52.3
Master degrees	14	6.5
Ph.D. degrees	1	.5
Medical specialist degrees	20	9.3
Type of Hospitals		
Beit hanoon hospital.	24	11.2
Kamal Odwan hospital.	27	12.6
Al Shifa medical complex.	42	19.6
Al aqsa martys hospital.	26	12.1
Nasser medical complex.	30	14.0
European Gaza hospital.	38	17.8
Abu yousef al-najjar hospital.	27	12.6

4.2 The frequency of anxiety scale

The following frequency table (4.2) describes the severity of anxiety due to work on emergency departments. The results that those who answered never to questions represent 38.3%, those who answered rarely to questions were 28.1%, and those who answered often were 22.7% and those who answered very often were 10.8%. It is shown that most answers were never and rarely.

Table (4.2) Frequency of anxiety symptoms from Hamilton Anxiety Scale

No.	Question	Never %	Rarely %	Often %	Very often %
1.	Anxious mood	17.8	40.2	30.8	11.2
2.	Tension	32.2	38.3	21.0	7.5
3.	Fear	50.5	27.6	16.4	5.1
4.	Insomnia	33.6	27.6	25.2	12.6
5.	Difficulties to concentration and memory	32.2	28.5	26.2	13.1
6.	Depressed mood	30.4	26.6	26.6	16.4
7.	General somatic symptoms (muscular)	29.0	26.6	27.6	16.8
8.	General somatic symptoms (sensory)	49.5	26.6	16.4	7.5
9.	Cardiovascular symptoms	43.0	27.6	18.7	10.7
10.	Psychological symptoms	35.5	36.0	18.7	9.8
11.	Abdominal and gastric symptoms	38.8	22.9	29.0	8.4
12.	Urinary tract symptoms	46.3	22.4	23.8	7.5
13.	Nerves system symptoms	49.1	19.6	21.5	9.8
14.	Behavior with meeting	47.2	22.4	15.9	14.5
	Cumulative Percentage	**38.3%**	**28.1%**	**22.7%**	**10.8%**

4.2.1 The severity and prevalence of anxiety symptoms among the study sample

The severity of anxiety symptoms according to research questions is shown in the following table shows where 99(46.3%) of the study sample have mild anxiety symptoms due to work on emergency departments, while 100(46.7%) of the study sample have moderate anxiety symptoms, and 15(7%) of the study sample have severe anxiety symptoms.

Table (4.3) The severity and prevalence of anxiety among study sample

Variables		**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**
Severity of anxiety	**No**	0	0	0	0
	Mild	99	46.3	46.3	46.3
	Moderate	100	46.7	46.7	93.0
	Severe	15	7.0	7.0	**100.0**
	Total	**214**	**100.0**	**100.0**	

(No=0-14 , mild=15-29 , moderate=30-44 , severe=45+)

4.3 Description of secondary trauma.

The secondary trauma check list is composed of three subscales: intrusion (items 2, 3, 6, 10, 13), avoidance (items 1, 5, 7, 9, 12, 14, 17), and arousal (items 4, 8, 11, 15, 16). Scores for the full secondary trauma symptoms (all items) and each subscale were obtained by summing the items.

Table (4.4) Frequency of dimension secondary trauma scale

Dimension	No.	Question	Never %	Rarely %	Often %	Very often %
Intrusion	2.	My heart started pounding when I thought about my work with clients	23.3	31.8	39.3	5.6
	3.	It seemed as if I was reliving the trauma(s) experienced by my client(s)	13.1	28	42.5	16.4
	6.	Reminders of my work with clients upset me	27.6	24.8	25.2	22.4
	10.	I thought about my work with clients when I didn't intend to	20.6	32.7	28	18.7
	13.	I had disturbing dreams about my work with clients.	37.9	24.8	23.4	14
Avoidance	1.	I felt emotionally numb	14	16.4	51.9	17.8
	5.	I felt discouraged about the future.	14	16.4	40.2	29.4
	7.	I had little interest in being around others	31.3	22	28	18.7
	9.	I was less active than usual	11.2	26.6	42.1	20.1
	12.	I avoided people, places, or things that reminded me of my work with clients	38.8	22.9	24.8	13.6
	14.	I wanted to avoid working with some clients	26.6	18.2	42.5	12.6
Arousal	17.	I noticed gaps in my memory about client sessions	28	30.8	27.2	13.6
	4.	I had trouble sleeping	19.2	30.4	23.6	16.8
	8.	I felt jumpy	11.2	26.6	42.1	20.1
	11.	I had trouble concentrating	20.1	36.4	30.8	12.6
	15.	I was easily annoyed	17.3	22.9	32.7	27.1
	16.	I expected something bad to happen	17.3	22.9	32.7	27.1

4.3.1 The prevalence of secondary trauma among the study sample

The prevalence of secondary trauma according to subscale are shown in the following table (4.7) where professional workers were most likely to have arousal symptoms (irritability reported by 75% of professionals workers), followed by avoidance symptoms (avoidance of patients 71.5%), and intrusion symptoms (intrusive thoughts about patients 70%). The prevalence of secondary trauma among emergency professional workers in this sample was 85% where at least one secondary trauma symptom was reported. Very concerning is the fact that 45% of the sample met the criterion for a diagnosis of secondary trauma.

Table (4.5) The Prevalence of secondary trauma among study sample

Variables		Mean	Percent %	Std. Deviation
Secondary trauma	Intrusion	2.3804	70%	.71034
	Avoidance	2.4546	71.5%	.64543
	Arousal	2.5467	75%	.68076

Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16).

4.4 Relationship among secondary trauma and anxiety symptoms according to socio-demographic variables

In order to analyze the relationship among secondary trauma and anxiety symptoms, according to socio-demographic variables for health professionals working at emergency departments. The analysis of the variables was done by using independent T-test and one-way ANOVA.

4.4.1 Differences between secondary trauma and anxiety symptoms according to sex

To test this relationship the researcher used the independent t-test analysis, to explore the relationship between variables.

There is a statistically significant difference among the means of secondary trauma according to sex (p-value =0.048): the highest anxiety symptoms effect was on males (mean = 2.08) and the lowest anxiety symptoms effect was on females (mean = 2.05).

There is a statistically significant between the means of anxiety symptoms according to sex (p-value =0.004): the highest anxiety symptoms effect was on males (mean = 2.4) and the lowest anxiety symptoms effect was on females (mean = 2.2).

Table (4.6) Differences of secondary trauma and anxiety symptoms according to sex

Variables	Sex	N	Mean	Std. Deviation	Std. Error Mean	T	Sig.
Anxiety symptoms	**Male**	193	2.0892	.70179	.05052		*.048
	Female	21	2.0578	.52713	.11503	3.969	
Secondary trauma	**Male**	193	2.4855	.62051	.04467		**0.004
	Female	21	2.2241	.36291	.07919	8.544	

*P<0.05 **P<0.01 ***P<0.001

4.4.2 Differences between secondary trauma and anxiety symptoms according to age group

To test this relationship the researcher used the one way ANOVA analysis.

From table (4.7) the results show that there is no statistically significant difference among the means of secondary trauma according to age (p-value =0.895).

There is a statistically significant difference among the means of anxiety symptoms according to age (p-value =0.001).

Table (4.7) One-way ANOVA comparison of secondary trauma and anxiety symptoms according to age group

Variables	Source of variance	Sum of Squares	df	Mean Square	F	Sig.
Anxiety symptoms	Between Groups	5.851	3	1.950	4.344	**.005
	Within Groups	94.287	210	.449		
	Total	100.138	213			
Secondary trauma	Between Groups	.224	3	.075	.202	.895
	Within Groups	77.630	210	.370		
	Total	**77.854**	**213**			

*P<0.05 **P<0.01 ***P<0.001

4.4.2.1 Comparison between secondary trauma and anxiety symptoms according to age group

Post-hoc analysis using Scheffe statistical test was done. The means of secondary trauma, previous traumatic events, and anxiety symptoms according to age group are shown in table (4.8).

All age groups 20-60 are affect equally with anxiety symptoms (mean = 2.4).

Table (4.8) Mean of secondary trauma and anxiety symptoms according to age group

Variables	Age group	N	Mean	Std. Deviation
Anxiety symptoms	**20-29**	110	1.9351	.66870
	30-39	71	2.1972	.69426
	40-49	29	2.3251	.64132
	50-60	4	2.5357	.31135
	Total	**214**	**2.0861**	**.68566**
Secondary trauma	**20-29**	110	2.4289	.61532
	30-39	71	2.4963	.61692
	40-49	29	2.4888	.57702
	50-60	4	2.4559	.36380
	Total	**214**	**2.4599**	**.60458**

4.5.3 Differences between secondary trauma and anxiety symptoms according to social status

To test this relationship the researcher used the one-way ANOVA analysis to explore the relationship between variables.

One-way ANOVA statistical test from table (4.9) found that there is no statistically significant difference among the means of secondary trauma according to social status (p-value =0.303).

There is no statistically significant difference among the means of anxiety symptoms according to social status (p-value =0.542).

Table (4.9) One-way ANOVA comparison between secondary trauma and anxiety symptoms according to social status

Variables	Source of variance	Sum of Squares	df	Mean Square	F	Sig.
Anxiety symptoms	Between Groups	.580	2	.290	.615	.542
	Within Groups	99.557	211	.472		
	Total	**100.138**	**213**			
Secondary trauma	Between Groups	.876	2	.438	1.200	.303
	Within Groups	76.978	211	.365		
	Total	**77.854**	**213**			

*P<0.05 **P<0.01 ***P<0.001

4.4.4 Differences between secondary trauma, previous traumatic events, and anxiety symptoms according to place of residence

To test this relationship the researcher used the one-way ANOVA analysis, to explore the relationships among variables.

There is no statistically significant difference among the means of secondary trauma according to place of residence, (p-value =0.847).

There is no statistically significant difference among the means of anxiety symptoms according to place of residence (p-value =0.899).

Table (4.10) One-way ANOVA comparison between secondary trauma and anxiety symptoms according to place of residence

Variables	Source of variance	Sum of Squares	df	Mean Square	F	Sig.
Anxiety symptoms	Between Groups	.509	4	.127	.267	.899
	Within Groups	99.629	209	.477		
	Total	**100.138**	**213**			
Secondary trauma	Between Groups	.510	4	.128	.345	.847
	Within Groups	77.344	209	.370		
	Total	**77.854**	**213**			

*P<0.05 **P<0.01 ***P<0.001

4.4.4.1 Comparison between secondary trauma and anxiety symptoms according to place of residence

Post-hoc analysis using Scheffe statistical test results are shown in table (4.11).
The effects of anxiety symptoms and secondary trauma are almost the same for all of the five governorates.

Table (4.11) Mean of secondary trauma and anxiety symptoms according to place of residence

Variables	Place of resident	N	Mean	Std. Deviation	Std. Error
Anxiety symptoms	North Gaza	45	2.0175	.61259	.09132
	Gaza	47	2.1641	.79817	.11642
	Middle	35	2.0857	.68573	.11591
	Khan-Younis	55	2.0727	.71316	.09616
	Rafah	32	2.0915	.57808	.10219
	Total	**214**	**2.0861**	**.68566**	**.04687**
Secondary trauma	North Gaza	45	2.4418	.50472	.07524
	Gaza	47	2.4593	.66002	.09627
	Middle	35	2.4924	.62840	.10622
	Khan-Younis	55	2.4011	.65328	.08809
	Rafah	32	2.5515	.55720	.09850
	Total	**214**	**2.4599**	**.60458**	**.04133**

4.4.5 Differences between secondary trauma and anxiety symptoms according to type of work

To test this relationship the researcher used the independent t-test analysis, to explore the relationship between both variables. Table (4.12) shows that:

There is a statistically significant difference among the means of anxiety symptoms according to type of work (p-value =0.009); the highest anxiety symptoms effect was on doctors (mean = 2.1) and the lowest was on nurses (mean = 2.0).

There is a statistically significant difference among the means of secondary trauma according to type of work (p-value =0.022); the highest secondary trauma effect was on doctors (mean = 2.5) and the lowest was on nurses (mean = 2.4).

Table (4.12) Independent T-test comparison between secondary trauma and anxiety symptoms according to type of work

Variables	Type professionals work	N	Mean	Std. Deviation	Std. Error Mean	T	Sig.
Anxiety symptoms	Doctor	78	2.1749	.59591	.06747	6.939	**.009
	Nurse	136	2.0352	.72942	.06255		
Secondary trauma	Doctor	78	2.5023	.55244	.06255	5.348	*.022
	Nurse	136	2.4356	.63324	.05430		

*P<0.05 **P<0.01 ***P<0.001

4.4.6 Differences between secondary trauma and anxiety symptoms according to education level

To test this relationship the researcher used one-way ANOVA analysis, to explore the relationship between variables.

There is a statistically significant difference among the means of anxiety symptoms according to education level (p-value =0.028).

There is a statistically significant difference among the means of secondary trauma according to education level (p-value =0.006).

Table (4.13) One-way ANOVA comparison between secondary trauma, previous traumatic events, and anxiety symptoms according to education level

Variables	Source of variance	Sum of Squares	df	Mean Square	F	Sig.
Anxiety symptoms	Between Groups	5.817	5	1.163	2.566	*.028
	Within Groups	94.320	208	.453		
	Total	**100.138**	**213**			
Secondary trauma	Between Groups	5.799	5	1.160	3.348	**.006
	Within Groups	72.055	208	.346		
	Total	**77.854**	**213**			

*P<0.05 **P<0.01 ***P<0.001

4.4.6.1 Comparison between secondary trauma and anxiety symptoms according to education level

Post-hoc analysis using Scheffe statistical test. Results are shown in table (4.14).

The highest anxiety symptoms effect was on Master degrees (mean = 2.5) and the lowest was on Practical nurse degrees (mean = 1.6).

The highest secondary trauma effect was on Master degrees (mean = 2.6) and the lowest was on Practical nurse degrees (mean = 1.9).

Table (4.14) Mean of secondary trauma and anxiety symptoms according to education level

Variables	Education level	N	Mean	Std. Deviation	Std. Error
Anxiety symptoms	Practical nurse degrees	12	1.6548	.56804	.16398
	Diploma degrees	55	1.9987	.64776	.08734
	Baccalaureate degrees	112	2.0950	.71656	.06771
	Master degrees	14	2.5051	.70847	.18935
	Doctor	3	1.9762	.78680	.45426
	Medical specialist degrees	18	2.2778	.44431	.10473
	Total	**214**	**2.0861**	**.68566**	**.04687**
Secondary trauma	Practical nurse degrees	12	1.9853	.67356	.19444
	Diploma degrees	55	2.3348	.55412	.07472
	Baccalaureate degrees	112	2.5625	.59465	.05619
	Master degrees	14	2.6765	.86075	.23004
	Doctor	3	2.1176	.56114	.32397
	Medical specialist degrees	18	2.4085	.23913	.05636
	Total	**214**	**2.4599**	**.60458**	**.04133**

4.4.7 Differences between Secondary trauma and anxiety symptoms according to hospitals

To test this relationship the researcher used the one-way ANOVA analysis. The results in table (4.15) show that:

There is no statistically significant difference among the means of anxiety symptoms according to hospitals (p-value =0.412).

There is no statistically significant difference among the means of secondary trauma according to hospitals (p-value =0.807).

Table (4.15) One-way ANOVA comparison between secondary trauma and anxiety symptoms according to hospitals

Variables	Source of variance	Sum of Squares	df	Mean Square	F	Sig.
Anxiety symptoms	Between Groups	2.881	6	.480	1.022	.412
	Within Groups	97.257	207	.470		
	Total	**100.138**	**213**			
Secondary trauma	Between Groups	1.116	6	.186	.502	.807
	Within Groups	76.738	207	.371		
	Total	**77.854**	**213**			

*P<0.05 **P<0.01 ***P<0.001

4.5.7.1 Comparing between secondary trauma and anxiety symptoms according to hospitals

Post-hoc analysis using Scheffe statistical test results are shown in table (4.16).
The highest secondry trauma effect was on Nasser Medical Complex by (mean = 2.6) and the lowest was on Al Aqsa Martys Hospital (mean = 2.3).

Table (4.16) Mean of secondary trauma and anxiety symptoms according to hospitals

Variables	Hospitals	N	Mean	Std. Deviation	Std. Error
Anxiety symptoms	Beit Hanoon Hospital.	24	1.9315	.53885	.10999
	Kamal Odwan Hospital.	27	2.0873	.76684	.14758
	Al Shifa Medical Complex.	42	2.2483	.80523	.12425
	Al Aqsa Martys Hospital.	26	1.9451	.61489	.12059
	Nasser Medical Complex.	30	2.1357	.69919	.12765
	European Gaza Hospital.	38	2.1523	.66389	.10770
	Abu Yousef El-Njjar Hospital	27	1.9577	.58071	.11176
	Total	**214**	**2.0861**	**.68566**	**.04687**
Secondary trauma	Beit Hanoon Hospital.	24	2.4877	.51207	.10453
	Kamal Odwan Hospital.	27	2.4096	.58083	.11178
	Al Shifa Medical Complex.	42	2.4244	.66074	.10196
	Al Aqsa Martys Hospital.	26	2.3733	.62981	.12352
	Nasser Medical Complex.	30	2.6020	.62247	.11365
	European Gaza Hospital.	38	2.5062	.66094	.10722
	Abu Yousef El-Njjar Hospital	27	2.4009	.50839	.09784
	Total	**214**	**2.4599**	**.60458**	**.04133**

4.5 Differences between secondary trauma and anxiety symptoms according to years of experience

To test this relationship the researcher used the one-way ANOVA analysis, to explore the relationship between both variables.

There is a statistically significant difference among the means of anxiety symptoms according to experience (p-value =0.000).

There is no statistically significant difference among the means of secondary trauma according to experience (p-value =0.032).

Table (4.17) One-way ANOVA comparison between secondary trauma and anxiety symptoms according to experience

Variables	Source of variance	Sum of Squares	df	Mean Square	F	Sig.
Anxiety symptoms	Between Groups	7.358	2	3.679	8.367	***.000
	Within Groups	92.779	211	.440		
	Total	**100.13**	**213**			
Secondary trauma	Between Groups	2.502	2	1.251	3.503	*.032
	Within Groups	75.353	211	.357		
	Total	**77.854**	**213**			

*P<0.05 **P<0.01 ***P<0.001

4.5.1 Comparison between secondary trauma and anxiety symptoms according to experience

Post-hoc analysis using Scheffe statistical test results are shown in table (4.19).
The highest anxiety symptoms effect was on those with 16 and more years of experience (mean = 2.6) and lowest was on those with 5 and below (mean = 1.9).
The highest secondary trauma effect was on those with 6-15 years of experience (mean = 2.6) and lowest was on those with 5 and below (mean = 1.3).

Table (4.18) Mean of secondary trauma and anxiety symptoms according to experience

Variables	Experience	N	Mean	Std. Deviation	Std. Error
Anxiety symptoms	5 and below	150	1.9690	.67715	.05529
	6-15	58	2.3325	.64882	.08519
	16 and more	6	2.6310	.30445	.12429
	Total	**214**	**2.0861**	**.68566**	**.04687**
Secondary trauma	5 and below	150	2.3914	.60846	.04968
	6-15	58	2.6359	.58900	.07734
	16 and more	6	2.4706	.28818	.11765
	Total	**214**	**2.4599**	**.60458**	**.04133**

4.6 Correlation between secondary trauma and anxiety among the study sample

Among the study sample results are shown in table (4.19).

Secondary trauma among anxiety symptoms the Pearson's correlation "R" is 0.737, and p = ***0.000, that means the high incidence of secondary trauma will combined with high incidence of anxiety, and reversible is right.

Table (2.19) Correlation among secondary trauma and anxiety, previous traumatic events among the study sample

	Secondary trauma	
Variables	**R**	**P-value**
Anxiety symptoms	0.737	***0.000

*P<0.05 **P<0.01 ***P<0.001

Chapter Five

Discussion and recommendations

Chapter Five

Discussion and recommendations

Introduction

This chapter introduces the main results that have been reached in chapter 4 and its discussion on the light of the previous studies. Furthermore, it's important here to clarify the results and its relation with other studies that may be helpful in supporting our finding. However, the researcher will put on the handsome of implication and recommendations regarding secondary trauma, previous traumatic events, and anxiety symptoms. That is likely to be taken in consideration in the application of the further building. Also, recommendations for further researches are provided on the basis of the results of the current study.

5.2 The main results

The study has been applied on all the doctors and professionals workers working at emergency departments in Gaza strip hospitals including Beit Hanoon Hospital, Kamal Odwan Hospital, Al Shifa Medical Complex, Al Aqsa Martys Hospital, Nasser Medical Complex, European Gaza Hospital, and Abu yousef al-najjar Hospital. The study consisted of 214 professional workers; 193(90.2%) males and 21(9.8%) females; 78(36.4%) doctors, and 136(63.6%) nurses.

The study showed a prevalence of secondary trauma among emergency professionals workers which mainly involved arousal symptoms (irritability reported by 75% of professionals workers), followed by avoidance symptoms (avoidance of patients 71.5%), and intrusion symptoms (intrusive thoughts about patients 70%). In this study sample 85% subjects reported at least one secondary trauma symptom. Very interesting is the fact that 45% of the sample met the criterion for a diagnosis of secondary trauma.

About 46.3%(99) of the study sample have mild anxiety symptoms due to work on emergency departments, while 100(46.7%) of the study sample have moderate anxiety symptoms, and 15(7%) of the study sample have sever anxiety symptoms the score was used mild=0-5, moderate=6-10, sever=11+.

Secondary trauma among anxiety symptoms the Pearson's correlation "R" is 0.737, and p = ***0.000, that means the high incidence of secondary trauma will combined with high incidence of anxiety, and reversible is right.

There was no statistically significant difference among the means of previous traumatic events according to sex (p-value =0.729).

There is a statistically significant difference among the means of secondary trauma according to sex (p-value =0.048). The highest anxiety symptoms effect was on males (mean = 2.08) and the lowest was on females (mean = 2.05).

There is a statistically significant difference among the means of anxiety symptoms according to sex (p-value =0.004). The highest anxiety symptoms effect was on males (mean = 2.4) and the lowest was on females (mean = 2.2).

There is no statistically significant difference among the means of secondary trauma according to age (p-value =0.895).

There is a statistically significant difference among the means of anxiety symptoms according to age (p-value =0.001). All age groups 20-60 are affected equally with anxiety symptoms (mean = 2.4).

There is no statistically significant difference among the means of secondary trauma according to social status (p-value =0.303).

There is no statistically significant difference among the means of anxiety symptoms according to social status (p-value =0.542).

There is no statistically significant difference among the means of secondary trauma according to place of residence (p-value =0.847).

There is no statistically significant difference among the means of anxiety symptoms according to place of residence (p-value =0.899).

There is no statistically significant difference among the means of previous traumatic events according to type of work (p-value =0.201).

There is a statistically significant difference among the means of anxiety symptoms according to type of work (p-value =0.009). The highest anxiety symptoms effect was on doctors (mean = 2.1) and the lowest was on nurses (mean = 2.0).

There is a statistically significant difference among the means of secondary trauma according to type of work (p-value =0.022). The highest secondary trauma effect was on doctors (mean = 2.5) and the lowest was on nurses (mean = 2.4).

There is a statistically significant between the means of anxiety symptoms according to education level (p-value =0.028). The highest anxiety symptoms effect was on master (mean = 2.5) and lowest was on practical nurse (mean = 1.6).

There is a statistically significant difference among the means of secondary trauma according to education level (p-value =0.006). The highest secondary trauma effect was on master (mean = 2.6) and the lowest was on practical nurse (mean = 1.9).

There is no statistically significant difference among the means of anxiety symptoms according to hospitals (p-value =0.412).

There is no statistically significant difference among the means of secondary trauma according to hospitals (p-value =0.807).

There is a statistically significant difference among the means of anxiety symptoms according to experience (p-value =0.000). The highest anxiety symptoms effect was on those with 16 and more years of experience (mean = 2.6) and lowest was on those with 5 and below (mean = 1.9).

There is statistically significant difference among the means of secondary trauma according to experience (p-value =0.032). The highest secondary trauma effect was on those with 6-15 years of experience (mean = 2.6) and lowest was on those with 5 and below (mean = 1.3).

5.3 Discussion:

The purpose of the present study was to examine the effect of secondary tramatization of health professionals working at emergency departments in Gaza strip hospitals on the mental health (Anxiety).

Professionals workers were most likely to have arousal symptoms (irritability reported by 75% of professionals workers), followed by avoidance symptoms (avoidance of patients 71.5%), and intrusion symptoms (intrusive thoughts about patients 70%). In this study sample 85% of the subjects reported at least one secondary trauma symptoms. Very interesting is the fact that 45% of the sample have met the criterion for a diagnosis of secondary trauma, which consistent with a previous study (Dominguez-Gomez and Rutledge, 2009) that found nurses were most likely to have arousal symptoms (irritability reported by 54% of nurses), followed by avoidance symptoms (avoidance of patients 52%), and Intrusion symptoms (intrusive thoughts about patients 46%). The majority of nurses (82%) reported at least one symptoms in the past week. Utilizing Bride's algorithm to identify STSS, 15% of nurses met no criteria, while 33% met all. Nurses' participation in stress management activities was associated with less prevalence of STS symptoms.

Three previous studies had found a significant relationship between therapist trauma history and secondary trauma (Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1999; Pearlman & MacIan, 1995), whereas four previous studies had found no significant relationship between therapist trauma history and secondary trauma (Follette et al., 1994; Schauben & Frazier, 1995). Our study found that Secondary trauma among anxiety symptoms the Pearson's correlation "R" is 0.737, and p=***0.000, that means the high incidence of secondary trauma will combined with high incidence of anxiety, and reversible is right. this is consistent with a previous study by Polit and Hungler (1999) concluded that for variables of a psychological nature, and R of .70 is high, meaning that the relationship between the variables has a strong positive correlation.

Most studies on secondary trauma have asked a subjective dichotomous question such as "Have you experienced trauma in your personal life? Do you have a trauma history?" (Pearlman & MacIan, 1995). But our study used secondary trauma check list of 56 statements made by persons who have been impacted by their work with traumatized clients, most professionals workers read each statement, and then indicates how frequently the statement was true for them in the past days. In our study

use secondary trauma whereas previous studies use this checks list of 17 statements (Bride, Robinson and Figley et al 1999, and Creamer and Liddle et al 2005).

However, Palestinian Shippers' Council (2007) reported that 2% have no anxiety; 39.8% have mild anxiety; 42.3% have moderate anxiety; and 15.8% have severe anxiety. this appeared to be consistent with our current study results where There were 46.3% of the study sample have mild anxiety symptoms due to work on emergency departments, while 46.7% of study sample have moderate anxiety symptoms, and 7%of study sample have severe anxiety symptoms. The researcher found that those who answered yes to questions were 38.24% and 61.73% answered no. In our study of 90.2% males and 9.8% females, there are statistically significant difference among the means of secondary trauma according to sex (p-value =0.048), the highest anxiety symptoms effect was on males (mean = 2.08) and the was on females (mean = 2.05). This is inconsistent with Cunningham's (2003) finding that 82% of social work clinicians rendering services to victims of trauma were females, and(e.g., Schauben & Frazier, 1995; Brady et al., 1999). As was reported earlier, studies that have examined gender differences in secondary trauma symptoms found that women reported more symptoms than men. Furthermore, this is consistent in Trippany et al (2003) study on factors influencing vicarious trauma, statistically significant difference among the means of vicarious trauma according to sex (p-value =0.02).

The study findings indicate that 51.4% of the professional workers in emergency departments age ranged from 20 to 29, which is not consistent with same previous studies Trippany et al (2004) found that most workers in emergency departments aged between 34 and 68. This explains that most of the new staff are pegging employed first time in the emergency departments because these departments need young staff because it's tiresome and needs more effort explain that most of the years of experience in emergency departments is below 5 years experience (70.1% of the workers). The results of the study showed that emergency department workers have a wide range of qualifications (table 4.1). The results of the study showed that 70.1% have below 5 years of experience, 27.1% from 6-15years, and 2.8% with more than 16 years. These findings suggest that the less experienced professionals workers work in emergency departments this explains why this mean these the highest secondary trauma effect was on 6-15 years of experience (mean = 2.6) and the lowest was on 5 and more (mean = 1.3). There was a statistically significant difference among the

means of secondary trauma according to experience (p-value =0.032). This is consistent with previous studies by Sabo et al. (2005) which showed a significant difference among the means of secondary trauma according to experience (p-value =0.023), and Cunningham (2003) who found that new and inexperienced staff was most likely to experience vicarious trauma.

The results showed that there was no statistically significant difference among the means of, secondary trauma according to place of residence, (p-value =0.847). This explains why there is no difference between those who live closer to the border with Israel and those who live in the center of the cities where suffer the two the same effects of secondary trauma.. All these reasons have had a clear affect on the results of the study.

5.4 Recommendations

This is the first study to document secondary trauma in emergency professionals workers using a reliable and valid tool. The findings of high levels of STS, as well as of individual symptoms, point to some needs and interventions:

- Further research with emergency professionals workers.
- Further examination of the potential differences in scoring among professional workers of different gender, ethnicity, and education, along with the differences in those who used specific coping strategies and those who did not, needs to be explored.
- Professional workers with STS may not be effective with patients, because their symptoms may disable optimal care giving, so, the employer should pay an attention to ouch condition.
- Managers should assume that a minority of emergency professional workers may be suffering from STS and, when appropriate, urge them to seek appropriate counseling or to use stress management techniques.
- Potential strategies identified in the literature include the use of formal and informal debriefing, providing the professionals workers staff with increased education on CF/STS, burnout, and death education, specifically to those who care for the dying patient and family.
- Other coping strategies identified include the use of organizational "team-building" activities, humor, reading, and alternative therapies, such as exercise, massage, and meditation.
- It is necessary from the international community to pressure Israel to stop violation of Palestinian rights and to allow free movement of people, goods, and necessary equipment and supplies.
- It is necessary from the international court of justice to pressure Israel to abide by the international conventions regarding human rights.
- Need for more long acting and new methods of intervention for professionals workers living in area of war and conflict to enable then to cope with secondary trauma and stress.

Reference

- Adam, S. (2008): Vicarious Traumatization: An Exploratory Study of Vicarious Trauma among Therapist Trainees, *journal of Training and Education in Professionals Psychology*, Vol. 2(1): 26–34.
- Adams, R. (2004): Compassion Fatigue: Compassion Fatigue and Psychological Distress among Social Workers, *International Journal of Emergency Mental Health,* Vol. (6): 57-66.
- Alford,. D., Mahone, C. and Fielstein, E. M. (1988): Cognitive and behavioral squeal of combat: conceptualization and implications for treatment. *Journal of Traumatic Stress,* Vol. 1(4):489-501.
- American Psychiatric Association, (1999): *Diagnostic and Statistical Manual of Mental Disorders*. Washington, D.C.
- American Psychiatric Association. (2000): *Diagnostic and statistical manual of mental disorders* (DSM IV-TR), fourth edition. Washington, DC: APA.
- Annscheutz, BL. (1999): The high cost of caring coping with workplace stress. *Ontario Association of Children's Aid Societies Journal* Vol. 43(3): 17 -21.
- Bilal MS, Rana MH, Rahim S, Ali S. (2007): Psychological trauma in a relief workers—*A case report from earthquake-struck areas of north Pakistan. Prehospital Disast Med* 2007; Vol. 22(5):458–461.
- Bloom, SL (1996): Bridging the black hole of trauma: Victims, artists and society. Unpublished manuscript.
- Brady, J. L., Guy, J. D., Poelstra, P. L.,&Browkaw, B. (1999): Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. Professionals Psychology: *Research and Practice*, Vol. 30(4), 386-393.
- Bride, B. & Robinson, M. & Figley, C. (1999): secondary traumatic stress: Development and Validation of the Secondary Traumatic Stress Scale**,** *Research on Social Work Practice*, Vol. 14(1): 27-35.
- Burns, N & Grove, SK. (1999): *Understanding nursing research*. 2nd edition. Philadelphia: Saunders.

- Byrne, M. & Lerias, D. (2006): Stress and Health: Predicting vicarious traumatization in those indirectly exposed to bush fires, *January of Stress and Health*, Vol. 22(5): 167–177.
- Collins, S. (2001): What about us? The psychological implications of dealing with trauma following the Omagh bombing. *Emergency Nurse*, Vol. 8(10): 9-13.
- Creamer, T. and Liddle, B. (2005): International Society for Traumatic Stress Studies**:** Secondary Traumatic Stress Among Disaster Mental Health Workers Responding to the September 11 Attacks, *Journal of Traumatic Stress*, Vol. 18 (1): 89–96.
- Cunningham, M. (2003): Impact of trauma work on social work clinicians: empirical findings. *Social Work Journal*, Vol. 48(4): 451-458.
- Dane, B & Chachkes, E. (2001): The cost of caring for patients with an illness, contagion to the social workers. *Social Work in Health Care*, Vol. 33(2): 31-51.
- De Silva, P. (1999): Cultural aspects of post traumatic stress disorder. In, Post traumatic stress disorder: *concept and therapy* (Eds.), Yule, W. Chichester, John Wiley & Sons. pp. 116-117.
- Deighton, R. & Gurris, N. & Traue, H. (2007): International Society for Traumatic Stress Studies: Factors Affecting Burnout and Compassion Fatigue in Psychotherapists Treating Torture Survivors: Is the Therapist's Attitude to Working Through Trauma Relevant?, *Journal of Traumatic Stress*, Vol. 20(1): 63–75.
- Dekel, R. and Solomon, Z. (2006): Secondary traumatization among wives of Israeli POWs: the role of POWs' distress, *Soc Psychiatry Epidemiology*, Vol. 10(41): 27–33.
- Dirkzwager, A. & Bramsen, I. (2005): American Psychological Association: Secondary Traumatization in Partners and Parents of Dutch Peacekeeping Soldiers, *Journal of Family Psychology*, Vol. 19(2): 217–226.
- Dominguez-Gomez, E. (2009): Emergency Nurses Association: prevalence of secondary traumatic stress among emergency nurses, *journal of emergency nursing*, Vol. 15(35):199-204.
- Figley, CR. (1999): Compassion fatigue: Towards a new understanding of the

cost of caring. In BH Stamm (ed.), Secondary traumatic stress: *self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.

- Fitzgerald Rice, K. & McAlister Groves B. (2005): "Hope and Healing: A Caregivers Guide to Helping Young Children Affected by Trauma. USA: ZERO to THREE.
- Follette, V. M., Polusny, M. M., & Milbeck, K. (1994): Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. Professionals Psychology: *Research and Practice*, Vol. 25(3), 275-282.
- Galea, S., Ahern, J., Resnick, H & Kilpatrick, D. (2002): Psychological squeal of the September 11 terrorist attacks in New York City. The New England *Journal of Medicine*, Vol. 346(13): 982-988.
- Ghahramanlou, M., & Brodbeck, C. (2000): Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health*, Vol. 2(4), 229-240.
- Greist, JH and Jefferson, JW. (2000): Anxiety Disorders. *Review of General Psychiatry* - 5th Edition by Vishal. McGraw-Hill, Medical Publishing Division, New York, NY 10121.
- Hattingh, SP. (2001): A model for the training of peer debriefers in the emergency services. Unpublished D. Phil Thesis. Pretoria. University of South Africa.
- Iliffe, G., Steed, L.G., (2000): Exploring the counselors experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence*, Vol. 15(4), 393–412.
- Jackson, K. E., Holzman, C., & Barnard, B. (1997): Working with sex offenders: The impact on practitioners. In S. B. Edmunds (Ed.), Impact: *Working with sexual abusers* (pp. 51-60). Brandon, VT: Safer Society Press.
- Jaffe, P. & Crooks, C. & Dunford-Jackson, B. & Town, J. (2003): Vicarious Trauma in Judges: Vicarious Trauma in Judges: The Personal Challengeof Dispensing Justice, *Journal of Juvenile and Family Court*, Vol. 3(1): 1-10.
- James, B. (1994): Handbook for treatment of attachment-trauma problems in children. New York: Lexington Books

- Jenkins, SR & Baird, S. (2002): Secondary traumatic stress and vicarious trauma: a validational study. *Journal of Traumatic Stress*, Vol. 15(5): 423-432.
- Kapur, R. (1999): Unconscious communications. *Interaction for practice in community nursing*. London: Mac Millan.
- Kassam-Adams, N. (1999): The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), Secondary traumatic stress: *Self care issues for clinicians, researchers and educators*, Vol. 2(15): 37-47.
- Marks 1M (1986): Genetics of fear and anxiety disorders. Br J Psychiatry,149:406.
- Maslach, C, Jackson, S & Leiter MP. (1996): *Maslach Burnout Inventory Manual*, 3rd edn. Consulting Psychologists Press, California.
- McCann, LI & Pearlman, LA. (1990): Vicarious Traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, Vol. 3(1): 131-149.
- Meichenbaum, D. (1994): A clinical Handbook Practical Therapist Manual for Assessing and Treating.
- Meltzer, L. & Zelikovsky, N. (2009): National Child Health Psychology Conference: The Experience of Secondary Traumatic Stress Upon Care Providers Working Within a Children's Hospital, *Journal of Pediatric Nursing*, Vol. 24(4) 29-40.
- MOH, (2009): Hospitals Annual Report 2008.
- Moulden, H. Firestone, P. (2007): Vicarious traumatization: The Impact on Therapists Who Work With Sexual Offenders**,** *January of trauma, violence, & abuse*, Vol. 8(1): 67-83.
- Naiiar, n. (2009): Compassion Fatigue: A Review of the Research to Date and Relevance to Cancer-care Providers, *Journal of Health Psychology*, Vol. 14(2) 267–277.
- Neuman, DA & Gamble, SJ. (1995): Issues in the professionals development of psychotherapists: countertransference and vicarious trauma in the new therapist. *Psychotherapy*, Vol. 14(32): 341-347.
- Ortlepp, K. (1998): Non-professionals trauma debriefers in the workplace: Individual and organizational antecedents and consequences of their

experiences. Unpublished doctoral thesis, University of the Witwatersrand, Johannesburg.

- Palestinian Red Crescent. (2008): Humanitarian Duty Report. PRC.
- Palestinian Shippers' Council (2007): Gaza Strip – Real Crisis – 2007 How long for?. The PSC is presently established in the context of an international technical cooperation project implemented by the United Nations Conference on Trade and Development (UNCTAD) and founded by the European Union (EU)".
- Palm KM, Polusny MA, Follette VM: Vicarious Traumatization: Potential Hazards and Interventions for Disaster and Trauma Workers. *Prehosp Disast Med*, Vol. 19(1):73–78.
- Pearlman, L. A. (1999): Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), Secondary traumatic stress: Self care issues for clinicians, *researchers and educators*, Vol. 2(9): 51-64.
- Pearlman, LA & Mac Ian, PS. (1995): Vicarious Traumatization: an empirical study of the effects of trauma works on trauma therapists. Professionals Psychology: *Research and Practice*, Vol. 26(6): 558-565.
- Pearlman, LA & Saakvitne, KW. (1995-a): Trauma and the therapist. United States of America Norton:.Professional Psychology: *Research and Practice*, Vol. 30(4), 386-393.
- Pearlman, LA & Saakvitne, KW. (1995-b): Treating therapists with vicarious traumatization and secondary traumatic stress disorder. In Figley CR. (Ed.) Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. New York, Brunner/Mazel.
- Pennebaker, J. W. (1997-b): Opening Up: The Healing Power of Expressing Emotions. New York: Guilford Press
- Perry, B. (2006): Effects of Previous traumatic events on Children. Retrieved May 15,2007, from http://www.childtrauma.org/ ctamaterials/interdis. Asp.
- Phipps A. & Byrne M. (2003): Brief interventions for secondary trauma: review and recommendations, *journal of Stress and Health*, Vol. 19(30): 139-147.
- Pol it, OF & Hungler, BP. (1999): Nursing research. *Principles and methods*. 6th ed. Philadelphia: Lippincott.

- Pol it, OF, Beck, CT & Hunglar, BP. (2001): Essentials of nursing research: *methods, appraisal and utilization*. Philadelphia: Lippincott.
- Polit, OF & Beck, CT. (2004): Nursing research. *Principles and methods*. 4th ed. Philadelphia :Lippincott.
- Sabin-Farrell, R.& Turpin, G. (2003): Departments of Clinical Psychology: Vicarious traumatization: implications for the mental health of health workers?, *journal of Clinical Psychology Review*, Vol. 23(20): 449–480.
- Sabo BM. et al. (2005): Compassion fatigue and nursing work: Can we accurately capture the consequences of caring work? *International Journal of Nursing Practice*, Vol. 25(12): 136–142.
- Sabo, B. (2006): Compassion fatigue and nursing work: Can we accurately capture the consequences of caring work?, *International Journal of Nursing Practice*, Vol. 23(12**)**: 136–142.
- Sarno, J.E. (1998): The Mind body Prescription: Healing the Body, Healing the Pain. New York.
- Schauben, LJ & Frazier, PA. (1995): Vicarious trauma: the effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, Vol. 4(19):49-64.
- Seligman, M. E. P. (1992): Helplessness: on development, depression, and death. New York: W. H.
- Sheehy, M. & Friedlander, M. (2009): American Psychological Association: The Relation of Secondary Traumatization to Therapists' Perceptions of the Working Alliance With Clients Who Commit Sexual Abuse, *Journal of Counseling Psychology*, Vol. 56(3): 461–467.
- Steed, L & Bicknell, J. (2001): Trauma and the therapist: The experience of therapists working with the perpetrators of sexual abuse. The Australasian Journal of Disaster and Trauma Studies, htpp:l/www.massey.ac.nz-trauma/issues/2001-1/steed.htm. 1 :1-9. Accessed on 2003.05.28 at 14H10.
- Thabet, A., Abu Tawahina, A., Vostanis, P. (2009): Coping with stress and siege in Palestinian families in the Gaza Strip (Cohort study III).
- Terr, L. (1990). Too Scared To Cry: Psychic Trauma in Childhood. New York: Harper & Row.

- Thomas, RP & Wilson, JP. (2004): Issues and controversies in the understanding and diagnosis of compassion fatigue, vicarious traumatization, and secondary traumatic stress disorder. *International Journal of Emergency Mental Health*, Vol. 6(2): 81-92.
- Thompson, R. (2003): Compassion fatigue: The professionals liability for caring too much .htpp:l/www. Riskinstitute.org Accessed on 2004.10.4 at 13H35.
- Trippany, R. & Kress, W. & Wilcoxon, A. (2004): American Counseling Association: Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors, *journal of counseling & development*, Vol. 82(6): 31–37.
- Van der Kolk, B. A., & Greenberg, M. S. (1987): The psychobiology of the trauma response.
- Van der Kolle, B. A. (1996): Trauma and memory. In B. A. Van der Kolle, C. McFarlane & L.
- Van der Kolle, B. A., & Ducey, C. P. (1989): The psychological processing of traumatic experience: *Warner Books*.
- Way, I. & Vandeusen, K. (2004): Vicarious Trauma: A Comparison of Clinicians Who Treat Survivors of Sexual Abuse and Sexual Offenders, *journal of interpersonal violence*, Vol. 19(1): 49-71.
- Weisberg, R. B., Culpepper, L., & Keller, M. B. (2002, May): The occurrence and course of mixed anxiety-depressive disorder in a sample of primary care patients. Paper presented at the meeting of the American Psychiatric Association, Philadelphia, PA.
- Yule, W. & Williams, R. M. (1990). Post traumatic stress reactions in children, Vol. 10(l): 279-295.

Annex 1
مقياس هاميلتون للقلق

اسم الحالة : .... تاريخ إجراء الاختبار.....
رقم الملف.....:
تعليمة : إليك هذا الاستبيان يحتوي على 14 فقرة ، المطلوب منك الإجابة عنها بوضع علامة (*) أمام الخانة التي تناسب حالتك ، و تأكد أنه لا توجد إجابة صحيحة أو خاطئة ، و أن معلوماتك ستكون في غاية السرية.
الخانات هي : لا توجد إعراض =0 أعراض طفيفة=1 أعراض متوسطة =2 أعراض شديدة 3= أعراض شديدة جدا=4
الفقرات:
01عسر المزاج:
التوجس و الشك، توقع الأسوأ أو الأشياء المخيفة، سهولة الاستثارة.
02التوتر:
مشاعر عدم الارتياح، سهولة الإجهاد، الفزع، سهولة البكاء، الارتجاف، لا يستقر على حال، لا يستطيع أن يترك نفسه على سجيتها
03الخوف:
من الظلام، و الغرباء والوحدة والحيوانات وزحمة المرور و الحشود .

04الأرق:
صعوبة الاستسلام للنوم ، النوم المتقطع ، نوم غير مشبع و الإحساس بالتعب عند الاستيقاظ ، أحلام و كوابيس ومخاوف ليلية.
05الذاكرة:
صعوبة التذكر وضعف الذاكرة .
06المزاج الاكتئابي:
اللامبالاة، لا يستمتع بالهوايات، الحزن، الاستيقاظ المبكر، انتقالات الانفعالات من النقيض إلى النقيض في اليوم الواحد.
07الأعراض الجسمية"العضلية "
ألام و أوجاع، التواء العضلات أو تيبسها، انتفاخ العضلات، صرير الأسنان، حشرجة الصوت، ازدياد الشد العضلي.
_____ _____ _____ _____ _____ _____ _____

08المشاعر الجسمية"الحسية"
طنين في الأذن، زغللة البصر، نوبات من السخونة والبرودة ، إحساس بالضعف.
_____ _____ _____ _____ _____ _____ _____

09أعراض القلب و الأوعية الدموية
اختلال ضربات القلب،ألام الصدر ، خفقان القلب ، انتفاض العروق، مشاعر الدوار .
_____ _____ _____ _____ _____ _____ _____

10أعراض تنفسية
ضيق الصدر أو اختناقه، مشاعر بالاختناق، التنهد، عسر التنفس.
_____ _____ _____ _____ _____ _____ _____

11الأعراض المعوية المعدية
صعوبة البلع، أرياح،ألام في البطن،حرقان المعدة،لين البراز،الشعور بامتلاء المعدة،الغثيان،القيء ،نقص الوزن، الإمساك ، أصوات البطن و الأمعاء.
_____ _____ _____ _____ _____ _____ _____

12أعراض المسالك البولية و التناسلية
زيادة عدد مرات التبول ، ضغط البول في المثانة، انقطاع العادة الشهرية، البرودة الجنسية، سرعة القذف، فقدان الرغبة الجنسية، العنة.
_____ _____ _____ _____ _____ _____

13أعراض الجهاز العصبي المستقل
جفاف الفم، احمرار الوجه، شحوب اللون، العرق، الدوار، صداع التوتر، وقوف الشعر.
_____ _____ _____ _____ _____ _____

14السلوك خلال المقابلة
تململ ، لا يستقر في مكانه،اهتزاز الأيدي، تقطيب الحاجبين، وجه مشدود، تنهيدات أو تلاحق الأنفاس، اصفرار الوجه، ابتلاع الريق ،التجشوء ، حركات مفاجئة في المفاصل، اتساع حدقة العينين وجحوظ العينين.
_____ _____ _____ _____ _____ _____ __

مفتاح التصحيح : بطريقتين: 1حساب درجات العامة لاستجابات المفحوص
2ملاحظة شدة كل عرض مثلا نجد فقرة أعراض تنفسية تحصل المفحوص فيها على درجة 4 وبعد مدة من الأيام تحصل على درجة 1 هنا نلاحظ أن المريض بدأ في تحسن

Annex 2

APPENDIX

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement, then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.

Never Rarely Occasionally Often Very Often

1. I felt emotionally numb.	1 2 3 4 5
2. My heart started pounding when I thought about my work with clients.	1 2 3 4 5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).	1 2 3 4 5
4. I had trouble sleeping.	1 2 3 4 5
5. I felt discouraged about the future.	1 2 3 4 5
6. Reminders of my work with clients upset me.	1 2 3 4 5
7. I had little interest in being around others.	1 2 3 4 5
8. I felt jumpy.	1 2 3 4 5
9. I was less active than usual.	1 2 3 4 5
10. I thought about my work with clients when I didn't intend to.	1 2 3 4 5
11. I had trouble concentrating.	1 2 3 4 5
12. I avoided people, places, or things that reminded me of my work with clients.	1 2 3 4 5
13. I had disturbing dreams about my work with clients.	1 2 3 4 5
14. I wanted to avoid working with some clients.	1 2 3 4 5
15. I was easily annoyed.	1 2 3 4 5
16. I expected something bad to happen.	1 2 3 4 5
17. I noticed gaps in my memory about client sessions.	1 2 3 4 5

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, and so forth.

Annex 3

بسم الله الرحمن الرحيم

يقوم الطالب بإجراء دراسة بعنوان" **مدى تأثير الصدمة الثانوية على موظفي أقسام الطوارئ في مستشفيات قطاع غزة**".
مع العلم أن: البيانات التي يتم الحصول عليها سوف تستخدم لأغراض البحث العلمي فقط.
المشاركة في البحث اختيارية وليست إجبارية.

شاكرين لكم حسن تعاونكم؛؛؛؛؛و الله الموفق الطالب

نادر مطر

استبيان الحالة الاجتماعية و الاقتصادية. ضع علامة X في المربع المناسب لكل عبارة .

1. **العمر** .....

2. **الجنس** ☐ ذكر ☐ أنثى

3. **الحالة الاجتماعية** ☐ أعزب ☐ متزوج ☐ مطلق ☐ أرمل

4. **مكان السكن** ☐ شمال غزة ☐ غزة ☐ الوسطى ☐ خان يونس ☐ رفح

5. **المهنة** ☐ طبيب ☐ تمريض/حكيم

6. **مستوى التعليم** ☐ ممرض عملي ☐ دبلوم ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه ☐ طبيب أخصائي

7. **المستشفى** ☐ بيت حانون ☐ كمال عدوان ☐ مجمع الشفاء ☐ شهداء الأقصى ☐ مجمع ناصر ☐ غزة الأوروبي ☐ أبو يوسف النجار

8. **عدد سنوات خبرة العمل في قسم الطوارئ** .....

- **عزيزي فيما يلي قائمة من العبارات التي وضعت بايدى أشخاص تأثروا بعملهم في العمل مع أشخاص مصابين و مرضى.**

الرجاء قراءة كل عبارة ثم قم ببيان إلى اى مدى كانت كل واحدة من العبارات صحيحة فيما يتعلق بك في عن طريق وضع علامة X في المربع المناسب لكل عبارة. أبدا , نادرا , أحيانا , غالبا.

السؤال	أبدا	نادرا	أحيانا	غالبا
1. هل تشعر بانفعالات شديدة.				
2. هل قلبك يبدأ بالخفقان عندما تفكر في عملك مع المرضى.				
3. هل تشعر كما أنك تعيش حالة الصدمة التي كان يعيشها المريض.				
4. هل أصبح عندك مشاكل في النوم.				
السؤال	**أبدا**	**نادرا**	**أحيانا**	**غالبا**
5. هل تشعر بالإحباط إزاء المستقبل.				
6. هل أصبح تذكرك لعمل مع المرضى يزعجك.				
7. هل أصبحت اقل اهتمام حاليا نحو الآخرين.				
8. هل شعرت بأنك أصبحت مُتقلب المزاج وعصبي.				
9. هل أصبحت أقل نشاطا من المعتاد.				
10. هل أصبحت تفكر في عملك مع المرضى في معظم الأوقات أو بمعنى أخر عندما لا تريد أن تفكر بهم.				
11. هل أصبحت تواجه صعوبة في التركيز.				
12. هل أصبحت تتجنب الناس و الأماكن و الأشياء التي تذكرك بعملك مع المرضى.				
13. هل أصبحت تحلم أحلاما مزعجة حول عملك مع المرضى.				
14. هل ترغب في تجنب العمل مع بعض المرضى.				
15. هل أصبحت تغضب بسرعة.				
16. هل أصبحت تتوقع أن يحدث شيء سيء.				
17. هل لاحظت ثغرات في عملك العلاجي مع المرضى.				

- **عزيزي/تي فيما يلي مجموعة من الأسئلة التي تقيس شعورك بالقلق, برجاء وضع علامة صح في الخانة الصحيحة**

السؤال	أبدا	نادرا	أحيانا	غالبا
18. هل أصبحت بشك، و بتوقع الأسوأ أو الأشياء المخيفة، و سهولة الاستثارة.				
19. هل بشعر بعدم الارتياح، سهولة الإجهاد، الفزع، سهولة البكاء، الارتجاف، و لا بستقر على حال.				
20. هل تخاف من الظلام، و الغرباء والوحدة والحيوانات وزحمة المرور و الحشود				
السؤال	**أبدا**	**نادرا**	**أحيانا**	**غالبا**
21. هل تعاني من صعوبة الاستسلام للنوم ، النوم المتقطع ، نوم غير مشبع و الإحساس بالتعب عند الاستيقاظ ، أحلام و كوابيس ومخاوف ليلية.				
22. هل تشكو من صعوبة التذكر وضعف الذاكرة .				
23. هل أصبح عندك اللامبالاة، عدم الاستمتع بالهوايات، الحزن، الاستيقاظ المبكر .				
24. هل تشعر بآلام و أوجاع، التواء العضلات أو تيبسها، انتفاخ العضلات، صرير الأسنان، حشرجة الصوت، ازدياد الشد العضلي.				
25. هل تعاني من طنين في الأذن، زغللة البصر، نوبات من السخونة والبرودة ، إحساس بالضعف.				
26. هل تعاني من اختلال ضربات القلب،ألام الصدر ، خفقان القلب ، انتفاض العروق، الشعور بلدوار .				
27. هل تشعر بضيق الصدر ، شعور بالاختناق، التنهد، عسر التنفس.				
28. هل تعاني صعوبة البلع، أرياح،ألام في البطن ،حرقان المعدة،لين البراز،الشعور بامتلاء المعدة،الغثيان،القيء ،نقص الوزن، الإمساك ، أصوات البطن و الأمعاء.				
29. هل تعاني من زيادة عدد مرات التبول ، ضغط البول في المثانة، انقطاع العادة الشهرية، البرودة الجنسية، سرعة القذف، فقدان الرغبة الجنسية.				
30. هل عندك جفاف بلفم، احمرار بلوجه، شحوب اللون، العرق، الدوار، صداع.				
31. هل بتقلمل ، لا بستقر في مكان،تشعر بلهتزاز الأيدي، تنهيدات أو تلاحق الأنفاس، ابتلاع الريق ، حركات مفاجئة في المفاصل.				

شاكرين لكم حسن تعاونكم؛؛؛؛؛و الله الموفق

الطالب. نادر مطر

جوال:0599607286

nadermatter@hotmail.com

Annex 4

35

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ7/6/2010

Name:

الاسم: نادر أحمد مطر

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Secondary Trauma among Health Professionals Working at Emergency Departments in Gaza Governorates.

In its meeting on June 2010

و ذلك في جلستها المنعقدة لشهر 6 2010

and decided the Following:-

و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member	Member	Chairperson
عضو	عضو	

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex 5

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

2010/5/22

حضرة الدكتور/ناصر أبو شعبان المحترم
مدير عام تنمية القوى البشرية – وزارة الصحة
تحية طيبة وبعد ،،،

الموضوع :مساعدة الطالب نادر مطر

يقوم الطالب المذكور أعلاه باجراء بحث بعنوان:

"Secondary Trauma among Health Professionals Working at Emergency Departments in Gaza Governorates"

كمتطلب للحصول على درجة الماجستير في الصحة النفسية المجتمعية ،وعليه نرجو التكرم والايعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات من أقسام الطوارئ في المستشفيات التالية :

1- م.كمال عدوان 2- م.بيت حانون 3- م.دار الشفاء 4- م. شهداء الأقصى
5- م.ناصر 6- م .غزة الأوروبي 7- م. أبو يوسف النجار .

علما بأن المعلومات ستكون متوفرة لدى الباحث والجامعة فقط .

شاكرين لكم حسن تعاونكم ودعمكم للمسيرة التعليمية .

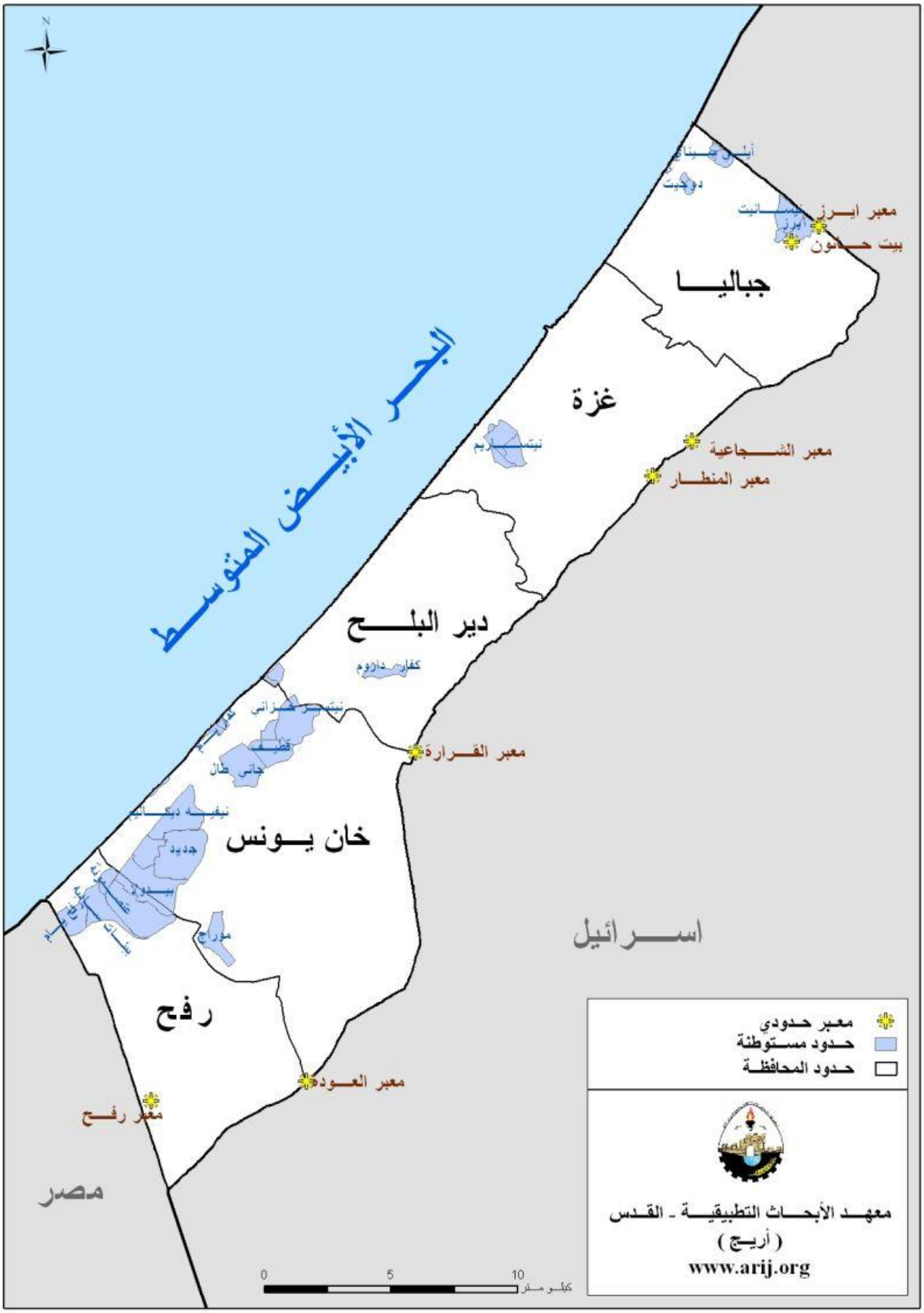
وتفضلوا بقبول وافر الاحترام والتقدير ،،،

د.عبد العزيز موسى ثابت
منسق برنامج الصحة النفسية المجتمعية
جامعة القدس – غزة

نسخة: الملف

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
فرع القدس/تلفاكس 02-2799234
فرع غزة/تلفاكس 08-2884422-2884411
ص.ب/51000-القدس

Annex 7


البحر الأبيض المتوسط
جباليا
غزة
دير البلح
خان يونس
رفح
مصر
اسرائيل
معبر ايرز
بيت حانون
معبر الشجاعية
معبر المنطار
معبر القرارة
معبر العودة
معبر رفح
معبر حدودي
حدود مستوطنة
حدود المحافظة
معهد الأبحاث التطبيقية - القدس
(أريج)
www.arij.org
0
5
10
كيلو متر