The Stress and Coping of Israeli Emergency Room Social Workers Following Terrorist Attacks

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The authors of this qualitative study analyze Israeli hospital social workers' emotional responses to working with civilian casualties in the wake of an unprecedented surge of terrorist violence. Data are based on four focus groups conducted with 38 hospital social workers in relation to their experience with clients in the emergency room. Three themes were identified: (a) Restoring a lost sense of personal security as a necessary stepping-stone toward resuming professional performance, (b) Meeting the families' pain and responding to it and, (c) Disconnecting emotionally in the service of the professional self. The authors discuss the findings in light of the literature on peritraumatic dissociation among helpers.

Keywords: terror; vicarious traumatization; dissociation; social workers; first responders; Israel

I n this article, we describe and analyze hospital social workers' emotional response to their work with civilian casualties in the setting of repeated terrorist attacks in Israel. Research and recommendations examining the effects of traumatic experiences on health care social workers is relatively rare, and what does exist tends to focus mostly on staff who have been assaulted by patients or on therapists

working with survivors of sexual abuse (Dickes, 2001; Trippany, 2001). Mental health workers who deal with distressing situations in their everyday work are perhaps expected not to react emotionally to traumatic events. However, evidence from ambulance workers suggests that even everyday traumas in emergency work take their toll (Clohessey & Ehlers, 1999), with 21% showing above-threshold symptoms of posttraumatic stress disorder (PTSD) (Bamber, 1994).

When helping professionals share the same traumatic event with their clients, multiple levels of vulnerability to traumatization emerge in working with survivors. The first is direct, or primary, traumatization, which refers to the direct effects of exposure to the traumatic event. The second is traumatization attributed to the effects of exposure on those to whom the therapist feels close. The third is vicarious traumatization, whereby the clients' unique experiences of the trauma are transferred to become part of the therapist's personal sense of vulnerability (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995; Saakvitne, 2002).

Indeed, working with traumatized clients can have profound, long-lasting, and harmful effects on helpers. Various terms to describe the phenomenon have been suggested. Herman (1992) used the term *traumatic countertransference* to describe the reactions that are experienced when the therapist's traumatic past experiences are triggered during therapeutic intervention with traumatized clients. Figley (1995) offered the term *compassion fatigue* to describe the stress resulting from helping or wanting to help traumatized or suffering clients. Courtois (1988), Eth and Pynoos (1985), Terr (1990), and Mollica (1988) suggested that therapists become "infected" by contagious PTSD symptoms. Likewise, Pearlman and MacIan (1995) proposed the concept of vicarious traumatization (VT) to portray the cumulative negative effects of engaging in a therapeutic relationship with trauma victims. This concept is based on a constructivist self-development theory (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995) and is assumed to affect the same general aspects of self as those affected by traumatic life events: self-capacities (e.g., management of affect, sense of self-worth), frames of reference (e.g., identity, worldview), basic beliefs and psychological needs (e.g., safety, esteem, control), and realms of perception and memory (e.g., verbal, somatic, visual imagery).

Although recently interest in VT has increased, only a handful of research studies have been conducted on this subject to date (Arvay & Uhlemann, 1996; Follette, Polusny, & Milbeck 1994; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Using survey methods incorporating standardized instruments, these researchers have provided important data on the general incidence of distress levels and on demographic indices among clinicians working with survivor populations. VT characterizes the effect of trauma on clinicians and other professionals who work with trauma survivors. In a recent study, Cunningham (2003) showed that clinicians who worked with clients who had been sexually abused reported more disruptions in cognitive schemas than clinicians who worked with clients who had cancer. Several authors reported that working with human-induced trauma might be more difficult for the clinician than working with naturally caused trauma (Danieli, 1994; Herman, 1992; Janoff-Bolman, 1992; Pearlman & Saakvitne, 1995). A unique situation exists, however, when the clinicians not only help survivors of human-induced trauma but are also personally threatened by the same potentially traumatizing circumstances. Recently, the direct traumatization of helpers was the focus of a survey of 1,064 health service staff involved in the Omagh bombing in Northern Ireland. Approximately half of the respondents who reported having

both professional and civilian involvement also exhibited higher levels of psychological symptomatology (Luce, Firth-Cozens, Midgley, & Burges, 2002). This study was unique, because the researchers investigated the impact of trauma on health service staff that had been part of the traumatized community that it served.

To the best of our knowledge, no research has been conducted on the meaning and nature of distress among mental health workers who are part of a traumatized community, despite the rampant threat of politically and religiously motivated violence nowadays. Terrorism, as this form of violence is otherwise termed, is aimed at instilling fear and confusion into the hearts of the entire community, generating an environment of chaos and insecurity (Merari, 1994). These deleterious effects inevitably make an impact on clients and mental health workers alike.

Since September 28, 2000, Israel has faced an unprecedented level of violent activities aimed at disrupting the life and morale of the community. This period has developed into the worst era of civilian bloodshed in Israel's history, representing an unparalleled threat to the nation. From the time of the eruption of this campaign until the collection of data for the present study, 653 attacks had been launched against Israeli civilians, resulting in the deaths of 5 individuals by stabbing, 8 by homicidal drivers, 15 by lynching, 91 by car- and other bombs, 128 by shooting, 261 by suicide bombers. In all, 643 Israelis, including civilians, law enforcement officers, and military personnel, perished, and more than 3,500 Israeli civilians, in a country of 6.5 million inhabitants, were physically injured during one year.[1] This is equivalent to 30,000 fatalities and 156,000 injuries in a country the size of the United States. Countless more are estimated to have suffered some sort of reactive psychological distress. Television, radio, Internet, and printed media coverage of these events is immediate, graphic, and extensive, contributing to the sense of a massive shared national crisis that engulfs survivors as well as unaffected citizens and mental health workers.

Many Israeli metropolitan medical centers have developed specific organizational models and response protocols in reaction to mass casualties following a terrorist attack. The model entails speedy interventions targeted to meet specific survivors in the community to facilitate needs and the establishment of network aid and support during the immediate crisis and in its long-term aftermath. Hospital-based social workers maintain preparedness by participating in training exercises, establishing coordination procedures, and engaging in periodic drills (e.g., Drory, Posen, Vilner, & Ginzburg, 1998; Rosenbaum, 1993). Immediately after an emergency situation is announced in the hospital, social workers are deployed to the emergency room reception area, where often hundreds of family members and friends gather to seek information about the medical condition of their loved ones. Special information desks and telephone lines are opened to disseminate information on the whereabouts of injured and missing individuals, which is constantly updated on the basis of data retrieved from the hospital computer. Additional rooms are also staffed by social workers for the provision of crisis intervention to highly distressed members of the public and for handling cases where the likelihood is high that a missing relative is among the casualties despite the absence of confirmatory information (Drory et al., 1998).

Although the literature offers some insights into the vicarious stress of social workers and other mental health professionals operating in the fields of family violence, child and sexual abuse, and disaster relief work, little has been written on the experience of mental health professionals under repeated terrorist attacks on their

communities. Moreover, most of the existing research focuses on measurement of predetermined indices, such as posttraumatic stress disorder. Very little is known about the nature of stress under such circumstances from insiders' perspectives.

In this study, we investigated the emotional reactions of these hospital-based social workers to their involvement in repeated emergency deployments following terror attacks in their communities.

METHOD

This study is based on four focus groups conducted with hospital social workers in relation to their experience with clients in the emergency room following terrorist attacks. We had two reasons for selecting focus groups as the research method: hospital organizational concerns and methodological interests. First, by using this approach, senior social workers within the medical center hoped to provide workers in a nonintrusive manner with an opportunity to discuss their experiences following a series of suicide bombings by labeling the activity a research project rather than a psychological intervention. Moreover, the supervisors hoped that focus groups would help the workers to identify important personal and professional issues critical to continuing optimal professional functioning during this unprecedented national crisis. Second, the researchers recognized that the focus group approach had several important positive qualities that were suitable for the specific group in this specific time: (a) It is relatively more cost-effective research than individual interviews. (b) It is a flexible technique allowing the discussion to evolve spontaneously, encouraging sharing, processing, and mutual support. We decided that this potentially friendly atmosphere would be particularly suitable for the distressed social workers under study. (c) This method can yield in-depth data through group interaction much more readily than through individual interviews (e.g., Krueger, 1994; Linhorst, 2002; Morgan, 1988, 1998, 2002).

Whereas focus groups are usually composed of 6 to 12 participants (Stewart & Shamdasani, 1990), each of our four focus groups consisted of 9 or 10 participants. Each author moderated two separate groups. In preparation for this procedure, the first two authors, in conjunction with the director of the hospital's social services department and the third author, co-developed research goals, participant inclusion criteria, the interview guide, and various scenarios for handling special ethical and sensitive potential situations related to hypothetical emotional developments in the focus groups (Krueger, 1994; Stewart & Shamdasani, 1990).

The first two authors, both faculty members at the School of Social Work at the local university, were the leaders of the focus groups. We were known to the management of the hospital's welfare services from our past involvement in teaching and research with their department. We had no current teaching or supervisory relationship with any of the participants, so dual relationships were nonexistent. Our impression was that our status promoted a sense of safety and trust that permitted candid sharing of difficult issues and feelings.

Sample

The sampling design was purposive (Patton, 2002), resulting in a homogeneous group of 38 social workers (37 women, 1 man) drawn from a large medical center in northern Israel. The age range of the participants was 25 to 53 years; 35 participants were Jewish, and 3 were Arab Christian; 28 were married, 8 were single, and 2 were divorced; and their professional experience in the field of social work ranged from 2 to 22 years. All of the hospital's social workers who had had one or more experience responding to the aftermath of a terrorist attack were invited to participate. Participation in the focus groups was voluntary and based on informed consent.

Ethical Considerations

Participants were informed that our aim in holding the focus group was to understand their perspectives on their work with victims of terror and their families and that a data-based report would be fed back to the departmental management for dissemination to participants. We also informed participants that data collected would be written up and submitted to a peer-reviewed journal. Participants agreed not to discuss personal information shared in the group with anybody other than the original group members. They were also reassured that all identifying data would be deleted from the transcripts and that all other potentially revealing information would be disguised. The focus groups' leaders formulated in advance guidelines for prevention of extreme emotional distress and possible interventions for the prevention of potential emotional harm. For example, we offered immediate support when intense emotional pain was expressed but discouraged graphic descriptions of disturbing memories and limited prolonged expressions of distress. In the groups, sharing was typically characterized by frankness and genuineness and was met with empathic listening and sincere support. One social worker seemed to have been excessively distressed by the group process. With her permission, we brought her condition to the attention of her supervisor, who followed up with caring support. This worker required no further assistance beyond the collegial help she had received.

Procedure

We used four basic research questions to guide the group discussion:

1. What are the main emotional issues that emergency room social workers must deal with following a terrorist attack?
2. What are the main professional issues that emergency room social workers must deal with following a terrorist attack?
3. What are the emotional needs of emergency room social workers in the aftermath of a terrorist attack? and
4. What are the professional needs of emergency room social workers in the aftermath of a terrorist attack?

These four core research questions were the basis for formulating a more detailed interview guide that included specific questions on the emotional reactions of the social workers, the nature of their distress, and how they coped with the extreme

stressors. The interview guide included questions that addressed both feelings and technique. Some examples are Describe the dominant feelings associated with your work following a terror attack, What are the main emotional properties of early interventions with survivors of terrorism and their relatives? Can you identify distinct emotional stages during this work? If so, please describe the main characteristics of each stage, Describe the emotional atmosphere that characterized your work as a team, and What were the ways of coping you adopted during the different stages of intervention? Items on the interview guide that addressed professional technique included Describe the main professional interventions you applied in the emergency room following a terror attack, both as individuals and as a team, Describe the reciprocal influences between your emotional reactions and the interventions you chose, and What are the relevant professional skills you feel you have mastered and what are the skills that you feel need to be improved for optimal performance in similar situations in the future? These questions were seen as a part of a potential pool of questions. The group leaders chose specific questions at their own discretion, depending on the evolving group discussion and dynamics. The answers provided in response to these questions were classified as reflecting either emotional or professional issues or needs.

The researchers-moderators used the developed topic guide with 10 written open-ended questions (Krueger, 1994; Morgan, 1988; Spradely, 1979), which provided direction but also allowed flexibility in interacting with the participants. Although the researcher-moderators took an active role in asking questions, the participants were eager to share their experiences, and the warm atmosphere created by peer-group interaction seemed to be conducive to free and open discussion. The decision to conduct single-session focus groups was mutually agreed with the participants to prevent an erroneous sense that the process was therapeutic in nature (thus implying participant psychopathology). The group interviews lasted until all attendees had addressed the research questions, a process that lasted about 2 hours. The proceedings were audiotaped and transcribed verbatim.

Data Analysis

This study was intended not to be generalized but to provide a more complete understanding of the nature of hospital social work in the wake of violent attacks. Therefore, concern was focused mainly on obtaining internal validity. This was achieved by forging collaboration between academics (the first two authors) and fieldworkers (the third and fourth authors) in the analysis of the findings and in grounding them with rich and full quotes. The third and fourth coauthors are experienced hospital social workers who have been intimately acquainted with the subject matter and have had unique insights into the investigated experience through both personal reflections and their ongoing interactions with their fellow hospital workers. We took care to ensure that the various aspects of the data collected would complement each other and that our results were trustworthy and valid (Lieblich, Tuval-Mashiach, & Zilber, 1998; Lincoln & Guba, 1985; Padgett, 1998).

The analysis was conducted in two main steps. In the first phase, the four authors separately read the four groups' transcribed discussions and systematically coded and sorted the material into key themes by means of cross-case analysis with a constant-comparison method. Core themes were identified and compared,

and analytical categories were later illustrated by specific quotations (Krueger, 1994).

Analysis until saturation was achieved in the following way: The four authors read the transcripts. Each researcher's examination of the data integrated instances from all interviews and reduced them until the core elements were reordered conceptually and placed back in the context derived from the larger interviews.

We then discussed the emerging themes until agreement was achieved concerning the themes, their titles, and a concise summary of each theme's content (the thematic map). In the next step, we agreed on the quotes to be presented as the illustrating data, their order, and the rationale for the chosen order of presentation. Every theme was allocated to either the first two or the last two authors, who worked as teams. Each team had forwarded memos containing their initial analysis to the other team for their review and comments. On average, three rounds of memos were exchanged until all comments were incorporated to the satisfaction of all authors. The revised themes were discussed at a concluding meeting, where saturation of the analysis and the corresponding quotes was determined (Creswell, 1998; Strauss & Corbin, 1990).

FINDINGS

Three main themes emerged from the interviews with the social workers in regard to coping with extreme stress in the overburdened emergency room and its aftereffects: (a) Restoring a lost sense of personal security as a necessary stepping-stone toward resuming professional performance, (b) Meeting the families' pain and responding to it, and (c) Emotional disconnection in the service of the professional self.

Restoring a Lost Sense of Personal Security as a Necessary Stepping-Stone Toward Resuming Professional Performance

The terror events and extremely stressful circumstances seemed to eliminate the boundaries between the personal and professional lives of the social workers, undermining their fundamental sense of control and proficiency. The first minutes between their call to duty and their actual professional engagement were characterized by a concerned response oriented to their immediate familial and social circles. Respondents seemed to react first as mothers, relatives, and potential victims, and as mental health professionals only afterward. Before attempting to take on their clinical responsibilities, many workers needed to get their personal distress under control by ascertaining the well-being of their loved ones. Yet, at the same time, they were intensely cognizant of the need to mobilize their strengths rapidly to face the threats and challenges posed by the traumatic situation:

> What I remember is: everybody in hysteria. I was on the ward, and I felt my own panic . . . First, I had to look for my children, [I thought] please don't let them go on a bus now. The telephone system collapsed, I couldn't get through. Everybody was on their phones not thinking about what was going on in the hospital . . . and finally

> my mother got through . . . as I heard her voice I burst into such tears that she got really scared . . . then I ran to [my post at] the hospital information center.

These workers described how their sense of safety had been shattered and how overwhelmed they felt after realizing their own vulnerability and that of their loved ones. The attack seemed to penetrate the respondents' defensive shield, creating the "hysteria" of the hospital workers as they attempted to ascertain their relatives' safety. Only after hearing her mother's voice on the phone was the first respondent able to collect her feelings and attend to her duties at the hospital's emergency information center.

Although attempting to adjust their personal sense of security, the social workers also described their exposure to an inordinate level of pressure and an intense assault on their senses:

> Although we had simulated mass disasters in the past, when terror struck I got really scared . . . the non-stop flow of wailing ambulances unloading their payload of victims, I counted 10, 20 ambulances . . . I was petrified.
>
> And I know what it looks like and how it smells. And it does have a smell. No one will convince me otherwise. The smell of burnt hair and scorched skin, it is something that until today I can smell from the end of the corridor, it simply gives me a tremendous sickening nausea.

These social workers describe how a shocking flood of unfamiliar, frightening, and repugnant stimuli overloaded their sensory systems, threatening to incapacitate them. This combination of peril and sensory overstimulation generates confusion, self-doubt, and a troubling sense of helplessness:

> I may have been involved with three terror attacks . . . initially, it is very terrifying when you get the message [about a terror attack], it is very scary. When the Yagur attack happened, I was at home, I watched the breaking news on TV, and then my beeper went off . . . my heart was pounding so hard despite the fact that I already had plenty of experience with incidents of trauma. So this is very daunting. The fear is [about] what to do and how to do it and whether or not we are performing properly . . . until I get to the site of the bombing or to the hospital, I experience a lot of worry and stress. By the time I get there, I have usually succeeded in switching off my brain to neutralize the feeling and to begin working "as I should."

Clearly, the acute personal distress experienced by this social worker initially overrides her role as helper. However, her awareness of her difficulties in controlling her anguish is accompanied by an awareness of her professional responsibilities, which ultimately assists her in integrating her professional and personal selves. Distressful reactions might reappear despite prior experience with terrorist attacks, and the overwhelming sense of dread and self-doubt must be "neutralized" by "switching off" these feelings.

Meeting the Families' Pain and Responding to It

Four main sources of emotional stress were associated with the rapid immersion into the personal and familial tragedies in the emergency room following a terror attack: the uncertainty and ambiguity involved in helping worried families to cope

with missing relatives and unidentified casualties; the task of notifying families about the demise of their loved ones; witnessing the families' anguished reactions and containing their psychic pain; and the respondents' identification with their clients' suffering. The blurred boundaries between the clients' pain and the social workers' personal distress, caused by both primary and secondary victimization, led many workers to experience difficulty in containing these emotions and carrying on with their professional duties.

One worker's account captures the essence of the ambiguity and pain endured by workers and clients alike who encountered difficulties in ascertaining the victims' identity because of their mental or physical condition:

> There were these members of two different families who believed that the same unidentified, unconscious person was *their* missing relative . . . this created confusion, helplessness, and huge discomfort . . . one person was 99 percent sure the victim was his relative . . . and then to have to offer support during the long nerve-racking wait outside the O.R. There was this other woman, unrelated to the first man, who was positive that this same anonymous patient was HER husband. I had to conceal the possibility that it may not be her husband they were operating on . . . this kind of ambiguity is very exhausting.

In this cruel quirk of fate, the social worker found herself supporting two anguished individuals, strangers to each other, who were each hoping that the unidentifiable injured patient was their missing relative. The desperate clinging to the hope that their missing family member had survived the terror attack was taxing to the worker because of the dreaded inevitability that soon at least one of them would have to face the unbearable loss.

The long wait with families for news about their missing relatives was exceedingly difficult for some workers, as is described by one respondent:

> All I could say was, "Let's wait, maybe something new will come up," but I was mostly silent. I looked into their eyes and couldn't say a word. I was petrified, paralyzed . . . I was afraid to feel.

Having any feeling at that point, let alone expressing it, might have implied an ominous prediction as to the fate of the missing family member. Freezing physically and emotionally was the social worker's selected course of action in face of this existential dilemma. Whereas some respondents assumed this kind of a non-interventionist stance to avoid encouraging a potentially forlorn hope, others felt guilty about fostering false optimism among individuals who claimed to be relatives of unidentified wounded patients.

As representatives of the authorities, some workers had to withstand hostile suspiciousness in the wake of the rapidly shifting emotional horror:

> I was with parents of a soldier, it was pretty clear . . . that he had been killed. I was waiting for the official announcement to be made. The father was very suspicious of me, he was sure I was hiding important information from him. He was restless . . . anything I said he misinterpreted like crazy. He was very agitated and had to be physically restrained on more than one occasion . . . and then the military delegation entered and both parents started screaming . . . I can't shake off their blood-curdling shrieks; they threw themselves on the corridor floors . . . This mother

sounded like a wounded animal. I couldn't control my tears . . . I knew I had to be there, but the helplessness.

Confronted by raw grief and suspicious hostility, this professional seemed to have comprehended the limitations of her helping skills under acute posttraumatic conditions. Under such circumstances, emotional identification with the victims' anguish and internalization of their pain can be so intense that some helpers can no longer differentiate between their distress and that of their clients:

I broke down on more than one occasion . . . there was this girl I was working with, her boyfriend had been killed. I found myself sitting in front of her, my tears streaming. Her father was consoling her . . . these would have been the exact words my father would have used. I identified with her so much I felt I was replacing her.

The poignantly tragic scenes that this interviewee talks about seem to dwarf and trivialize her repertoire of skills, leaving her disheartened by her feelings of professional inadequacy. In these social workers' accounts, expressions of doubt can be heard regarding the relevance of mental health care in immediate disaster response:

This family was waiting for hours to hear about the fate of their missing relatives. They had been eating at the bombed restaurant . . . They must have known that their relatives could not have survived. We knew it, but had to wait for the official confirmation from the coroner's office before notifying them. I was looking at them, saying to myself—"Oh my God, I will soon have to leave the nursing station to tell them. I want so much to be done with this already" . . . The most difficult moment was when we gathered the family. This woman lost her husband and her two sons . . . I just sat next to her and wept. She was so quite obviously stunned. Maybe it would have been easier for me had they been more expressive, I don't know.

Long periods of silence shrouded the focus groups as participants lowered their heads in sad reflection on those instances requiring notification of the death of a loved one. These were seasoned professionals whose line of duty at the medical center often brought them close to death. Nothing, however, had prepared them for the arbitrary nature of the senseless slaughter perpetrated by the suicide bombers in their communities. Their professional dissatisfaction and sense of helplessness prompted a handful of them actively to explore possible alternative meanings for their presence in the emergency rooms. It was not always feasible, but many participants were successful in identifying the significance of their role during the crisis:

One of the mothers I supported asked me to remember the events for her [to be her memory]. She literally wanted me to record the drama in my mind as if to save a copy of it for safekeeping. She did not ask this of other family members who were there. They were probably too overwhelmed. She asked me to share this burden with her. I sensed her relief as I paid attention.

The worker focuses on the special role entrusted to her by the family of the victim: that of a witness, a partner in carrying the intolerable recollection, an auxiliary memory holder who could later help the surviving relatives to process their grief. This bestowed role gave the social worker a continuing constructive function in the client's world. Although worried, confused, and frightened, the quoted worker, like

many of her colleagues, felt a sense of meaning in fulfilling her duties especially in the containment of the families' anguish and their support. Although still unsure about exactly what professional intervention was most appropriate under such extraordinary circumstances, they had at least managed to forge some sense of significance and organization out of the chaos in the emergency room.

Emotional Disconnection in the Service of the Professional Self

The interviewees described their emotional distress under the repeated traumatizing events as overwhelming. Maintaining a detached and effective professional performance under these circumstances becomes a continuous challenge. This condition is particularly challenging when helpers are confronted by the realization that they are part of the attacked community. The recognition of personal connections between victims and caretakers seemed to have been a turning point in the level of adaptive functioning for some social workers, hampering the maintenance of adequate emotional distance between themselves and their clients. Emotional disconnection and distancing was often the coping strategy used by these social workers to protect themselves from the traumatic reality and the confusing professional quandary that they faced:

> One woman called in to inquire about a couple I knew personally. This stressed me out so much I started to weep . . . I moved to the treatment center to work with the arriving families and I'll tell you exactly what I did. The police came in and said they needed our assistance. Relatives of the missing were asked to help identify some of the corpses. Family members were wailing. This was a very scary experience. I suddenly went empty, I felt nothing, I was in shock [smiling], no, I'm not sure it was shock; it was as if I was outside myself. I took myself and put it aside and told myself that I had to do something and do it well.

The distancing response used by this emergency room social worker in reaction to the realization that she had been personally acquainted with the slain couple helped her to gain sufficient distance from the tragedy in order perform adequately as a professional.

Although the practice of manual-style procedures on the rapid deployment of emergency hospital welfare centers can give structure to an otherwise chaotic environment, dissociation further assisted the workers in responding effectively to devastated family members:

> The most meaningful thing I do after [takes a deep breath] is that I emotionally disconnect . . . this emotional dissociation helps me not to break down in front of the traumatized families.

Not all of the respondents seemed to understand the nature of their defensive reactions. Several social workers wondered about the appropriateness of their feelings during the critical event and seemed embarrassed to reveal how the protective advantage of this emotional disconnection had later distanced them from their clients. Their descriptions were replete with examples on how this defense had hindered their wish to be more emotionally available to their clients:

> Maybe I'm a weird girl . . . I mean, emotionally; I didn't feel much . . . I was very calm. Later, however, I had to consciously put an effort into staying emotionally available to the families.

This worker's self-reference as "weird" reveals her concern that she might be perceived by the focus group and its facilitator as deviant. Although this concern was not substantiated by the group, as other participants shared similar defensive reactions that they had experienced, she clearly expected herself to perform her duties but remain emotionally present and connected with her clients.

Despite their apparent professional involvement in the emergency room, some social workers described complete forgetting of the events. In some cases, these reactions seemed to develop into an apparent dissociative amnestic episode:

> I have a hard time with this situation here . . . there was too much blood, too much suffering. I need to leave it all behind . . . During the event I was on "automatic pilot," I don't have any memories . . . although I do know I felt self-confident . . . I realize now that I can delete stuff from my memory.

This worker claimed that she had no memory of the critical event and was convinced that she had successfully erased it from her mind. However, she contradicted herself by protesting that the discussion in the focus group triggered some of the agonizing experiences that she would have rather not remembered, thus revealing at least an implicit painful memory. The usefulness of immediate emotional distancing is evident in her reported ability to go on "automatic pilot" so as to intervene with assurance and self-confidence.

It seems that the first hospital experience following the horror of a terrorist bombing might be the most difficult to remember:

> I was involved in three bombings . . . I am trying to recall my first experience following the suicide bombing at H. Junction [the event had occurred about 7 months prior to the focus group interview] . . . I have no idea what my duties were, what families I worked with, how I functioned, nothing . . . but I do have memories of the next two disasters.

Apparently, for this social worker, the first attack in a series of terrorist incidents in Haifa had shattered her basic assumption of safety and was probably the hardest to come to terms with and to comprehend. The amnesia for this incident might have been commensurate with the level of shock and distress experienced on her first exposure to terrorism.

DISCUSSION

In a review of the literature on PTSD among emergency services personnel, Bamber (1994) highlighted the widely held idea that professional helpers are somehow immune to suffering the same sort of distress as those they are helping. Our findings show that this is by no means the case. The most prominent factor in the inability to maintain emotional distance between Israeli social workers and their terrorized clients was the fact that these professionals were integral elements of the attacked community. Not only were their cognitive schemas about safety threatened, their

sense of personal safety was endangered as well. Workers needed to allay their fears and worries about the security of their loved ones before they were able to project themselves into their professional roles.

The social workers' accounts thus reflect a paradoxical situation: Although they had been trained to respond in emergency situations and were fairly knowledgeable about potential scenarios, they were overwhelmed by the sheer magnitude and swift onslaught of devastating sensory stimulation. Such human drama cannot be rehearsed in simulated situations—the sounds of wailing sirens, moaning patients, panicking relatives, and shouting staff, combined with the sight of bodily disfiguration and the unfamiliar, acrid smell of burnt flesh.

Discussing combat stress, Noy (1991) argued that there is a tendency for emotions to be exaggerated in a polarized manner. Similarly, social workers in our focus groups reported that they had experienced either no emotional stress or a severe level of stress. Only after they managed to shut out offensive elements of their reality were they able to muster their professional resources with a heightened sense of duty. This challenge was translated into a self-evaluation of their success in coping with the crisis.

Peritraumatic dissociation is a common psychological reaction to trauma, whereby an individual emotionally detaches at the time of the upsetting ordeal. Many who have experienced peritraumatic dissociation report feeling as though the events happened in slow motion, as if in a dream, or as though they were watching a movie (Carden & Spiegel, 1993; Marmar, Weiss, & Metzler, 1998). Our data reveal that peritraumatic dissociation played an important role in our respondents' adjustment to the traumatizing conditions. Models suggesting that trauma can induce dissociative reactions have been highly supported by retrospective and prospective studies of peritraumatic dissociation (Koopman, Classen, & Spiegel, 1994; Shalev, Peri, Canetti, & Schreiber, 1996). Our data show that some social workers even developed dissociative amnesia in reaction to the traumatic events following a terror attack. The literature indicates that in the aftermath of trauma, some individuals find themselves unable to retrieve all of their trauma memories (Brown, Scheflin, & Whitfield, 1999), whereas others fail to access trauma memories altogether (Van der Hart & Brom, 2000).

The evidence also suggests a relationship between dissociation during a traumatic event and the later development of PTSD (e.g., Marmar, Weiss, Schlenger, et al., 1994). Researchers theorize that whereas peritraumatic dissociation might be adaptive during a traumatic event, subsequent use of this mechanism for coping with feelings of distress when reminded of the trauma might lead to survivors' failure to process adequately the trauma, including both its meaning and the emotions associated with the experience (Tichenor, Marmar, Weiss, Metzler, & Ronfeldt, 1996). Ultimately, this might result in the development of more severe or delayed posttraumatic psychopathology.

For the most part, alterations in one's integrated memory and experience system are probably transient. However, we believe that the exposure of hospital mental health professionals, who are normally not a part of emergency response teams, to mass disasters might put them at risk for the development of posttraumatic psychopathology. McCann and Pearlman (1990b) have argued that when traumatic memories are very significant to the mental health professional insofar as they relate closely to personal needs and life experiences, and when the experiences of the traumatic event are not discussed, distressing traumatic memories can become

lastingly integrated into the helper's memory system. The dissociation reported by our respondents, however, can also be seen as an ordinary adjustment attempt designed to help them carry on with their "normal" personal lives while living with the constant threat of terrorist attacks as a part of their daily existence.

A critical aspect in the work of trauma clinicians is the challenge of transforming vicarious traumatization. Because healing psychological trauma requires the conscious examination of meaning (Frankl, 1959; Janoff-Bulman, 1992), the attenuation of vicarious traumatization calls for us to create meaning and infuse everyday activities with meaning. This process should include an examination of the significance of trauma work to clinicians. Why do we do this hard work? What are the costs, and what are the benefits of the work to each of us? As Saakvitne (2002) observed, therapeutic work with trauma survivors can change both the therapists themselves and their experiences of the tragedies that they face.

THEORETICAL AND CLINICAL IMPLICATIONS
FOR THE HELPING PROFESSIONS

Although data from qualitative research are context dependent, and our results are, arguably, pertinent to the Israeli experience only, these findings are congruent with those presented by Wee and Myers (2002) regarding stress responses of mental health workers following the Oklahoma City bombing. Our data might represent universal reactions of mental health workers who are part of a community devastated by a catastrophic disaster. The findings of this qualitative investigation suggest that VT is a useful concept in understanding the impact of terrorism on social workers operating as first responders in hospital emergency rooms. Cunningham (2003) differentiated between naturally caused and human-induced trauma, and showed that clinicians who worked primarily with clients who were victims of sexual violence reported more distress than clinicians who worked with clients who had cancer. Our study implies that direct exposure of first responders from the helping professions to the horrors of war and terrorism might constitute another category of potential traumatization for the helping professional that is not only vicarious but also primary in nature. Recognition that providing psychosocial services under the duress of direct exposure to potentially traumatizing threats might have deleterious results for the professional is critical for adequate training and responsible aftercare for these health workers. The inherent difficulties in creating credible simulations of real threats pose considerable difficulties in devising effective training to inoculate against the harmful effects of war and terrorism on the helping professional. Special training should include discussion of the impact of trauma work on the health care provider, the viewing of documentary materials of similar situations, and role-played simulations of interventions during catastrophic events.

We discovered that despite this sort of training, preparation, and exposure to emergency situations, some social workers were better equipped to handle the demanding circumstances than others. A final implication of this study is the need to develop effective selection procedures for those who are invited to participate in potentially traumatizing work. Only informed and consenting professionals who are identified as at low risk for VT should then be asked to participate in this high-risk work.

Four main limitations of this study need to be considered when interpreting the results. First, it is possible that the work relationship between participants and the fact that they had to face each other after the focus group ended might have stifled some valuable sharing of personal information. Second, the limit placed on us by the management of the hospital social welfare department to conduct the focus groups in a single session might have further compromised the richness of material provided to us. Additional meetings with these professionals might have further facilitated the atmosphere of trust and self-disclosure to yield more data. The third limitation relates to the fact that this study was carried out at one medical center only. It is conceivable that the experience of teams operating in other cities and different professional milieus would present somewhat different emphases on these experiences. Fourth, we believe that it is important to explore the stress and coping in related disciplines such as medicine, nursing, psychiatry, and psychology rather than focusing solely on social workers.

Since the operation of the focus groups reported in this article, two major terrorist attacks have been committed against the same Haifa community, taking the lives of 38 civilians and wounding many others. Once again, the social workers we interviewed for this article bravely managed the innumerable tragedies that unfolded in their hospital emergency rooms.

NOTES

1. Statistics on civilian and military casualties are available on the Israel Defense Forces' Web site (http://www1.idf.il/dover/site/mainpage.asp?sl=EN&id=22&docid=16703).

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