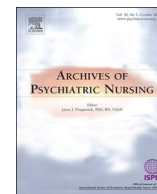




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Post-traumatic Stress Disorder Among Health Care Providers Two Years Following the Israeli Attacks Against Gaza Strip in August 2014: Another Call for Policy Intervention

Nasser Ibrahim Abu-El-Noor^{a,*}, Yousef Ibrahim Aljeesh^b, Abdal-Karim Said Radwan^b,
Mysoon Khalil Abu-El-Noor^b, Ibrahim Abdel-Ilhady Qddura^b, Khalid Jamal Khadoura^b,
Samer Khader Alnawajha^c

^a College of Nursing, Islamic University of Gaza, P.O. Box 108, Gaza, Gaza Strip, State of Palestine

^b College of Nursing, Islamic University of Gaza, State of Palestine

^c University College of Applied Sciences, State of Palestine

Introduction

Post-traumatic stress disorder (PTSD) is a common, disabling disorder that appears after the exposure to a traumatic experience (Nemeroff et al., 2006). Post-traumatic stress leads to a pattern of symptoms that include a delayed response to an acute stressful and a life-threatening event or situation, such as combat exposure during war time (Lavoie, Talbot, & Mathieu, 2011). These symptoms may appear either during or immediately after the occurrence of the event, or several days later. The symptoms include initially intense fear, helplessness, or horror. Later, the individual develops a response to the stressful event that is characterized by persistently re-experiencing the event, with resultant symptoms of numbness, avoidance and hyperarousal (Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006). According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), diagnostic criteria for PTSD require the onset of 17 characteristic symptoms following exposure to an extreme stressor (Criterion A1) and a reaction to that stressor that involves fear, helplessness, or horror (Criterion A2). Further, post-traumatic symptoms must be present for more than one month and include intrusive recollections of the traumatic event (Criterion B; at least 1 symptom), avoidant symptoms (Criterion C; at least 3 symptoms), and hyperarousal symptoms (Criterion D; at least 2 symptoms) (American Psychiatric Association, 2000). A few years later, the fifth edition of the DSM (American Psychiatric Association, 2013) proposed four distinct diagnostic clusters instead of three: re-experiencing symptoms (at least 1 symptom), avoidant symptoms (at least 1 symptom), negative alterations in cognitions and mood (at least 2 symptoms), and arousal symptoms (at least 2 symptoms). According to both editions of the DSM, symptoms of PTSD must persist for more than one month and must cause clinically significant distress or impairment in functioning.

After exposure to a stressful or a traumatic event, one usually

experience agitation, anxiety and sleep disturbance (McCarthy, 2001). Half of those who experience posttraumatic nightmares may have dreams that exactly replicate the traumatic event (Davis, Byrd, Rhudy, & Wright, 2007; Wittmann, Schredlm, & Kramer, 2007). Moreover, they may have trouble in concentration and they try to avoid reminders of the event (American Psychiatric Association, 2000). In the last two decades, research revealed that traumatic events occur far more often than what it was previously assumed (Kessler, 2000; Weathers & Keane, 2007) and that PTSD is a highly prevalent condition with great impact on human and society well-being and costs (Kessler, 2000).

Individuals exposed to combat exposure in a war zone are not only at risk to experience trauma but typically they may experience multiple traumatic experiences (Rossignol & Chandler, 2010). The combination of the stressful hospital environment during a war time and the individual experiences outside the work could expose nurses and other health care providers to a greater number of traumatic stressors which subsequently could lead to PTSD (Hodgetts, Broers, Godwin, Bowering, & Hasanovic, 2003). Hospital personnel are considered at high risk for severe injuries and mortality as part of their work, especially during war time. They will deal with masses of wounded people who are admitted to the hospital in a relatively short time. The increased number of admissions and the type of casualties during war time creates an extreme pressure on hospital personnel (Ben-Ezra, Palgi, & Essar, 2008).

Besides the extra physical stress during such times, the extreme exposure of hospital personnel to repeated and continued high number of casualties and dead bodies is directly related to worsened functioning (March, 1993). Moreover, witnessing death and serious injuries to others is a sufficient stressful event to cause PTSD (Carson et al., 2000).

Posttraumatic stress symptoms among hospital personnel are relatively understudied (Ben-Ezra et al., 2008; Kerasiotis & Motta, 2004;

* Corresponding author.

E-mail addresses: naselnoor@iugaza.edu.ps (N.I. Abu-El-Noor), yjeesh@iugaza.edu.ps (Y.I. Aljeesh), arodwan@iugaza.edu.ps (A.-K.S. Radwan), maziz@iugaza.edu.ps (M.K. Abu-El-Noor), iqddura@iugaza.edu.ps (I.A.-I. Qddura).

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Luce, Firth-Cozens, Midgley, & Burges, 2002). Several studies revealed that hospital personnel exposed to war experience had developed PTSD. For example, one study revealed that > 30% of American nurses who served during Vietnam war experienced PTSD-related symptoms (Paul, 1985). Another study revealed that 3.3% of those nurses who still in active duty had PTSD 20 years after the war (Stretch, Vail, & Maloney, 1985). A more recent study revealed that 10.5% of Israeli physicians and 35.7% of nurses who were working in Ramabm Hospital in Haifa during the war between Israel and Lebanon (July 12, 2006-August 14, 2006) experienced PTSD (Ben-Ezra et al., 2008). Nurses who were involved in Vietnam War with chronic PTSD reported abandoning nursing career, on-going, struggles with anger, involving in relationships in which they could not receive love, and a foreboding sense in their current lives (Buechler, 2007). Furthermore, being under direct threat toward one's life, family members, and friends while treating others is known to enhance emotional distress, burnout, and other negative consequences among mental health workers (Dekel & Baum, 2009).

Studies within the Palestinian context related to trauma are limited. One study was conducted by Alhajjar (2014) and aimed to examine the relationship between exposure to war stress and posttraumatic symptoms among nurses in all Gaza hospitals after the Israeli war on Gaza on 2012. Results revealed that 69.4% of nurses suffered from high levels of PTSD symptoms. In another study, results revealed that about 70.1% of children and adolescents between the ages of 9 and 18 years who were exposed to the on-going Israeli-Palestinian conflict to have PTSD (Thabet, Abu Tawahina, El Sarraj, & Vostanis, 2008). Similarly, Elbedour, Onwuegbuzie, Ghannam, Whitcome, and Abu Hein (2007) found that 68.9% of Palestinian adolescents (age 15–19 years) living in Gaza Strip have PTSD (Elbedour et al., 2007). Moreover, a comparative study conducted by Pat-Horenczyk et al. (2009) revealed that 37.2% of Palestinian adolescents compared to 6.8% of Israeli adolescents met the criteria for PTSD.

In the last decade, Gaza Strip was a target for four offensives by Israel during the years 2006, 2008, 2012, and 2014. The last war continued from July, 7th until August, 26th, 2014. According to the Palestinian Center for Human Rights (2014), the war left 2191 deaths (2205 according to OCHA (United Nations Office for the Coordination of Humanitarian Affairs), 2014a) and 10,895 wounded. Approximately, 30% of wounded people were children. About 18,000 housing units were destroyed or severely damaged and about 108,000 Palestinians became homeless as they were forced to evacuate their houses and moved to shelter areas (OCHA (United Nations Office for the Coordination of Humanitarian Affairs), 2014a). People living in Gaza Strip encountered a wide variety of psychological and physical distress during that time which could affect all domains of their quality of life (QOL).

During this war, 33 health care providers were killed and 251 were injured (Ministry of health-Palestinian Health Information Center, 2015). Moreover, 17 hospitals and 50 primary health care centres have reported damage to their infrastructure (OCHA (United Nations Office for the Coordination of Humanitarian Affairs), 2014b).

Hospital personnel working on Gaza hospitals have encountered several stressors during the war time that included personal threats to their lives, their families and their clients, especially that many hospitals were targets for bombardment by the Israelis.

In spite of the abundant studies about PTSD, only a few number of them have systematically examined the effect of health care providers and hospital personnel's exposure to extreme stress (Ben-Ezra, Palgi, & Essar, 2007; Hodgetts et al., 2003; Luce et al., 2002). In a previous study, we aimed to assess the level of PTSD and to examine the relationship between exposure to war stress and posttraumatic symptoms among health care providers following Israeli offensives against Gaza Strip in 2014. Data were collected three months after the offensives. Results revealed that 89.8% of participants suffered from PTSD (Abu-El-Noor et al., 2016). In this study, we aimed to examine if there were any changes of our previous results after two years of the war.

Materials and methods

A cross-sectional design was used to conduct this study. The target population for the study was all nurses and doctors who were working at emergency rooms, operation rooms, intensive care units (ICU), surgical departments, and burn units during the 2014 war. These departments were chosen because they received most of the victims of the 2014 war. Therefore, nurses and doctors who started working at these units after August 2014 were excluded from this study. We used a census population that included all nurses and doctors who were working during the war time in the same departments and in the same three hospitals that were used in our previous study (Abu-El-Noor et al., 2016).

Instrument

The Impact Event Scale-Revised (IES-R) was used in this study (Weiss & Marmar, 1997). The original Impact Event Scale (IES) predated the introduction of the diagnosis of PTSD. It is comprised of 15 items that measure two symptom clusters of PTSD; seven items measure intrusions and eight items measure avoidance related to a negative event (Horowitz, Wilner, & Alvarez, 1979). The revision of the original IES was done by Weiss and Marmar to better match the DSM-IV criteria for PTSD. As a result, a third cluster of symptoms that consists of seven items (hyperarousal subscale) was added to the original IES and its now known as IES-R.

The IES-R is a self-report questionnaire that consists of 22 items measuring post-traumatic stress symptoms in three clusters: intrusion (seven items), avoidance (eight items) and hyperarousal (seven items). Participants are asked to rate how frequently each symptom has been distressing for each participant during the past seven days with respect to the specified potentially stressful event on a 5-point Likert scale (where 0 - not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely).

The IES-R has demonstrated good psychometric properties (Weiss, 2004). Briere (1977) reported that the internal consistency of the three subscales were found to be very high, with intrusion Cronbach's alphas ranging from 0.87 to 0.92, avoidance Cronbach's alphas ranging from 0.84 to 0.86, and hyperarousal Cronbach's alphas ranging from 0.79 to 0.90. Currently, IES-R is considered one of the most widely used measures to assess posttraumatic stress symptoms (Elhai, Gray, Kashdan, & Franklin, 2005).

The cut-off score for IES-R varies between 22 and 44 with a score above the cut-off indicating a person at a high risk for psychological problems (Dyregrov & Gjestad, 2003). Considering the variations of cut-off points used in different studies in different groups of participants and different cultures, the investigators chose a cut-off point of 35 for severe posttraumatic symptoms. Choosing a score of 35 as a cut point was because it relatively falls in the middle of the recommended range between 22 and 44. Moreover; it was used in a similar study by Alhajjar (2014) and in our previous study (Abu-El-Noor et al., 2016).

The instrument was translated into the Arabic language in our previous study (Abu-El-Noor et al., 2016) by two independent bilingual researchers. Then the two Arabic versions were compared and double checked for accuracy until common agreement about a final translation was agreed upon. Conceptual rather than the literal meaning was the goal of the translation. The final Arabic version was then back translated into the English language by a third bilingual researcher. Back-translation is a standard procedure for translating a research questionnaire from English to other languages (Kim, Schwartz-Barcott, Holter, & Lorensen, 1995). Reliability Coefficients (Cronbach's alpha) of the Arabic IES-R subscales were: 0.817, 0.779, 0.713 respectively, and 0.892 for total IES-R (Abu-El-Noor et al., 2016).

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