CAUSES AND MANIFESTATIONS OF SECONDARY TRAUMATIZATION AMONG ARAB TRAUMA THERAPISTS IN ISRAEL: THE SHARED TRAUMA PHENOMENON

SOCIOPOLITICAL CONTEXT, COMMUNITY PROXIMITY, AND THE PHENOMENOLOGY OF SECONDARY TRAUMATIC STRESS

Awda Gnaiem Hossen

Department of Psychology, Varna Free University — Bulgaria

Abstract: *Social workers and trauma therapists in Arab society in Israel operate within a uniquely complex professional environment shaped by overlapping layers of sociopolitical marginalization, community-level trauma, and systemic underservice. This article examines the phenomenon of secondary traumatization among Arab social workers and trauma therapists in Israel, and the structural conditions that produce it, focusing on Figley and Ludick's (2016) Compassion Fatigue Resilience (CFR) Model. Drawing on qualitative data from semi-structured interviews with 25 licensed social workers and trauma therapists from Arab communities in Israel, the study identifies the socio-political, communal, and interpersonal structures that generate secondary traumatization, and documents its psychosomatic, affective, and cognitive manifestations.*

The findings show that therapists experience a condition of "shared trauma"—operating within the same socially fractured and violence-permeated communities as their clients—which intensifies vulnerability to secondary traumatization beyond what existing Western models predict. This vulnerability is not static: it is dynamically activated and amplified during periods of national-collective crisis. Following the events of October 7th and the subsequent war on Gaza, participants described a distinct escalation of psychological burden rooted not in individual clinical exposure but in collective political and historical trauma, accompanied by a pattern of professional silencing experienced by Arab therapists working within mixed Jewish-Arab teams. The article proposes an integrative cultural-ecological framework that incorporates a temporal, event-sensitive dimension of shared trauma, and calls for institutional reforms addressing the structural neglect of Arab mental health infrastructure in Israel.

Keywords: *secondary traumatization, compassion fatigue resilience, Arab social workers, Israel, shared trauma, collective trauma reactivation, qualitative research*

1. Introduction

The emotional and psychological toll of working with traumatized clients has been widely recognized across the helping professions. Secondary traumatic stress (STS), compassion fatigue, and vicarious traumatization have emerged as significant occupational hazards for therapists, social workers, and other practitioners engaged in sustained exposure to clients' traumatic experiences (Figley, 1995; Stamm, 2010). Yet the existing literature has developed primarily within Western, individualist frameworks that insufficiently address the distinctive conditions facing therapists from collectivist minority communities, especially those in whom therapist and client inhabit the same fractured social world.

Arab society in Israel represents one such distinctive context. Comprising approximately 21% of Israel's citizenry (Sippel et al., 2015), this minority population navigates complex intersections of Palestinian heritage, Israeli civic identity, religious commitment, and the ongoing experience of structural discrimination. Social workers and trauma therapists embedded in this context face a dual burden: they carry the professional weight of therapeutic exposure while simultaneously sharing the sociopolitical and existential conditions of their clients. This convergence—what participants in the current study describe as "shared trauma"—constitutes a theoretical and clinical challenge that existing STS models have not adequately addressed.

Shared trauma, as documented in this study, is not a stable structural condition alone. Following the events of October 7th and the subsequent war on Gaza, participants described a distinct escalation of psychological burden rooted not in individual clinical exposure but in collective political and historical trauma—accompanied by a pattern of professional silencing within mixed Jewish-Arab work environments. Participants also described how humor, peer ventilation, and informal self-care function as collective—not merely individual—responses to this burden; these coping and resilience dimensions are treated in a companion article addressing the resources therapists draw upon to withstand secondary traumatization.

This article presents findings from a qualitative study involving 25 semi-structured interviews with Arab social workers and trauma therapists in Israel, focused on the structural causes and clinical manifestations of secondary traumatization. Its theoretical

contribution lies in applying Figley and Ludick's (2016) Compassion Fatigue Resilience (CFR) Model, together with cultural-ecological perspectives, to take seriously the role of sociopolitical context, community structure, and the temporal-political dimension of collective trauma as context-specific factors shaping secondary traumatization. By centering the voices and experiences of Arab therapists, the study seeks to expand the conceptual landscape of secondary traumatization research and generate empirically grounded recommendations for culturally adapted professional support.

2. Theoretical Framework

2.1 Secondary Traumatization: Conceptual Foundations

Secondary Traumatic Stress (STS) was first systematically conceptualized by Charles Figley (1982, 1995), who defined it as the emotional duress arising when a helping professional is exposed to another's firsthand traumatic experience through an empathic relationship. Figley's foundational insight was that the very qualities essential to therapeutic effectiveness—empathy, compassion, and emotional attunement—simultaneously constitute the primary pathways through which STS is acquired. This "empathy paradox" (Ludick & Figley, 2016) lies at the heart of secondary traumatization theory: the capacity to care for the suffering other is inseparable from the risk of absorbing that suffering.

Related constructs have been developed to capture different aspects of this phenomenon. Vicarious traumatization, grounded in constructivist self-development theory, refers to the long-term transformation of the therapist's inner world—including disrupted cognitive schemas about safety, trust, and meaning—resulting from sustained empathic engagement with trauma material (McCann & Pearlman, 1990). Compassion fatigue emphasizes the acute affective dimension of caregiver exhaustion, incorporating both secondary traumatic stress and burnout (Rauvola et al., 2019).

2.2 The Compassion Fatigue Resilience (CFR) Model

The Compassion Fatigue Resilience (CFR) Model (Ludick & Figley, 2016) provides the most comprehensive theoretical architecture for understanding both risk and protection in STS. Organized across three sectors—the empathic stance, secondary traumatic stress, and compassion fatigue resilience—the model identifies twelve interacting variables that collectively determine a practitioner's resilience profile. The

empathic stance encompasses exposure to suffering, empathic concern, and empathic ability; the secondary traumatic stress sector highlights the role of residual compassion stress, traumatic memory reactivation, and the burden of life demands outside the therapeutic context.

The protective pathways identified within the model's third sector—compassion fatigue resilience—are addressed in a companion article. The present article focuses on the model's empathic-stance and secondary-traumatic-stress sectors, which were developed primarily in Western clinical contexts and do not fully account for the structural conditions that shape exposure for therapists in collectivist, minority, and conflict-affected settings such as Arab society in Israel. The current study engages precisely this gap: the findings presented below suggest that the model requires a temporal dimension, since exposure is not a fixed quantity but fluctuates in response to collective political events external to the clinical encounter itself.

3. Methodology

This study employs a qualitative research design guided by an interpretive phenomenological approach. Twenty-five semi-structured interviews were conducted with licensed social workers and trauma therapists who are Palestinian Arab citizens of the State of Israel, working in Arab communities across northern and central Israel. Participants were recruited through purposive and snowball sampling, with inclusion criteria requiring at least one year of professional experience in trauma-focused therapeutic work. All interviews were conducted in Arabic—the participants' mother tongue—to facilitate authentic expression and minimize linguistic mediation effects. Interviews lasted between 75 and 120 minutes and were audio-recorded with participants' informed consent.

Data were analyzed using thematic analysis (Braun & Clarke, 2006) with iterative coding across three analytical stages: open coding, thematic clustering, and theoretical integration. The analysis paid particular attention to material relating to the October 7th attacks and the war on Gaza, which entered the interview material as the political landscape shifted during the data collection and analysis period. To ensure analytical rigor, member checking was conducted with a subset of participants, and a reflexivity journal was maintained throughout the analysis process to document the researcher's positionality as

an Arab social worker and researcher embedded in the communities under study. Participants' names have been replaced with pseudonyms throughout this article.

4. Findings

The thematic analysis yielded interconnected themes that together illuminate the structural causes and clinical manifestations of secondary traumatization among Arab social workers in Israel. This article addresses four of these themes: the ethical and experiential roots of professional vocation; the socio-political reality as a structural context of secondary traumatization, including the reactivation of historical collective trauma; community proximity and boundary complexity; and the psychosomatic, affective, and cognitive manifestations of secondary traumatization. A companion article addresses the remaining themes concerning the resources therapists draw upon to withstand this burden.

4.1 The Ethical and Experiential Roots of Professional Vocation

For most participants, the decision to enter the therapeutic profession was experienced not as a career choice but as a moral calling deeply intertwined with personal biography and communal identity. Three primary pathways were identified: entry motivated by a commitment to social change within Arab society; entry precipitated by personal trauma or loss; and entry through a gradual discovery of professional meaning.

Iyad, reflecting on his early years in the profession despite minimal compensation, articulated a widely shared sentiment:

"I remember my first years in the job, when the salary conditions were very low. Even in a full-time position, the pay barely reached six or seven thousand shekels, and sometimes even less. Despite that, there was a strong sense of commitment to the profession and to the social endeavor. For me, social work is first and foremost a mission. Especially when it involves working within my own community, something that carries deep meaning for me."

Asked directly about the meaning social work provides, he continued:

"Listen, the meaning is social change, I simply believe in it, that social change begins with working with people who are on the margins, and that's exactly what social work does. You know, we Arabs suffer from discrimination and inequality, so social work isn't just a profession, it's an active act to promote social change. You can see the change

at the individual and community level, it's a long and exhausting process, but it gives meaning to my work, to my existence."

Samira articulated a comparable commitment to the village of her upbringing:

"I started studying social work without really understanding what it involved, you know, we [young Arabs] start studying at a very young age and don't always really understand what we're getting into. During my first year I fell in love with the profession and understood I was in the right place, I waited to finish my studies in order to go back to my village and start making the change, to use the tools I learned. I wanted to promote the change, my village is very poor, and I understood how much poverty is not a decree of fate, and that we can improve for the better the place we're emotionally connected to."

Personal trauma history was also reported as a significant motivating factor. Ahlam described how losing her mother at age ten shaped her therapeutic orientation:

"I decided to work in this after going through a very difficult crisis, after I lost my mother at a very young age, I was ten years old when she died of illness. Throughout my life, especially in adolescence, she was very much missed. So when I finished my studies, it was clear to me that I was going to work in a therapeutic profession."

Asked why the choice felt so clear to her, she responded:

"I think first of all I wanted to understand what I myself went through, how the loss at a young age affected me—at the time I maybe didn't know how to say it, but now, yes, I know. I also think I wanted to help people who are in the place where I once was as a girl, out of a belief that I do understand their experience and I can help them, especially since I myself didn't receive such help as an orphan."

Nahed connected her entry into the field to an experience of sexual assault:

"I think unconsciously I wanted to help other women who went through sexual assault like me. As a teenager I went through sexual assault and received help from a social worker. I will never forget that in my life, she accompanied me the whole way and was there for me. So it seems to me that I wanted to give that back to others, and support people who went through crises, exactly as I received support myself when I needed it."

Manar described a difficult home environment that shaped her professional path:

"I grew up in a house with a lot of problems, my brother was addicted to drugs, and I don't remember us having a normal family life. I think I chose the therapeutic profession in order to treat myself first and foremost."

For a third group of participants, professional meaning emerged gradually rather than through an initial vocational decision. Nada described her entry into the field as almost incidental:

"Getting into the field was, honestly, a bit accidental. I enrolled at the Hebrew University mainly because I wanted to study at a prestigious institution—that was also my father's dream. But what gave me real direction was my homeroom teacher, who always told me I was suited for this profession. Something in his words stayed with me."

Asked about the meaning her work holds today, she added:

"Meaning, for me, is feeling that someone needs me and that I really do manage to help others. This understanding, that I'm necessary and important to clients, makes me feel self-worth—the understanding that I truly matter."

Diana described the satisfaction she derives from the therapeutic process:

"I love seeing how a person moves from one place to another, even if they take a small step, it makes me feel a sense of accomplishment that I managed to do something called treatment. Since I was a small child I would lend a hand and help others, it always satisfied me—made me feel good about myself."

4.2 The Socio-Political Reality as a Structural Context of Secondary Traumatization

Participants consistently described their professional work as embedded within a macro-context of structural discrimination, institutional neglect, and endemic violence—conditions that directly shape both the intensity of STS exposure and the availability of institutional protective resources.

4.2.1 "An Orphaned Society": Institutional Abandonment and Discrimination

Participants described a profound sense of state abandonment, using the striking phrase "orphaned society" to characterize the institutional neglect experienced by Arab communities in Israel. Manar stated:

"First of all, in my opinion something basic is missing: the state doesn't see us. It's missing recognition of us as part of the state, like Jewish citizens, first-class. It's missing

understanding and seeing our needs. I feel that Arab society is, in a certain sense, an orphaned society, because the state doesn't really relate to us as its citizens."

Yasmin extended this observation to the professional standing of Arab social workers specifically:

"Because we're social workers from Arab society, the state doesn't give us all the rights that are due to us as citizens, you feel that we're second-class, priority and encouragement and rights are always given to Jewish society."

Nada elaborated on how this institutional discrimination is internalized, describing a state she termed learned helplessness:

"Sometimes I feel a kind of learned helplessness—as a result of knowing there's social oppression, that there's structural injustice built into the reality of a deprived Arab minority. You know it, you live it—and it's not always easy to carry this understanding alongside the pain of clients."

4.2.2 The Gap Between the Institutional Therapeutic Model and Field Reality in Arab Society

Participants consistently identified a mismatch between institutionally mandated therapeutic models and the realities of practice in Arab communities. Renin explained how interventions designed without cultural sensitivity are set up to fail:

"In reality, when we wanted to implement the practice in Arab society, we said—wait, who said you can host a strange girl in a house that doesn't belong to relatives, how might this affect her biological family too. We cause the response to fail from the outset when we don't adapt it socially and culturally."

Sameh sharpened the disjunction between institutional emergency protocols and organic community practice:

"I see the institutional perspective—in an emergency the state wants us to work according to what it wants, but we as Arabs don't work that way. There's a gap between the conception and reality itself."

Beyond the mismatch of intervention programs, Nada described a related gap in mutual understanding between Jewish and Arab colleagues that compounds professional isolation:

"Sometimes I feel that I'm alone—that the issues I raise [with Jewish colleagues] aren't understood, and sometimes simply not of interest. There's a feeling that I need to manage on my own and find solutions without real support. At times I also feel judgment toward the cases I bring—and that, in my opinion, reflects a lack of understanding and ignorance of the reality I live and work in."

4.2.3 Under the Shadow of Violence and Crime: The Erosion of Personal Security

Alongside the sense of institutional abandonment described above, participants offered extensive testimony regarding the reality of violence and crime in Arab towns. Participants described violence and crime as having become an inseparable part of the daily routine of both therapists and clients alike; this constant presence generates vigilance and anxiety for family safety that erodes even the most basic sense of resilience. Arin described the continuous exposure to news of murder and its cumulative psychological toll:

"We wake up to news of people who were murdered and go to sleep after news of people who were murdered—people like me and like you. It's so hard. It happens in every town, in every neighborhood. You go to sleep to the sound of gunshots and wake up to them."

Ahlam described a concrete erosion of personal security that compels families to restrict their children's freedom of movement:

"In our town people are afraid to go out at certain hours, and I'm sure that's true across Arab towns generally. We [she and her partner] make a list of places the children can spend time in—in the past we didn't do that. This is an abnormal reality we've been living in for several years, and it keeps getting worse over time."

Several participants described their work as occurring within a condition in which therapist and client share the same social reality; the combination of violence, crime in Arab society, and institutional discrimination places therapists in a state of trauma shared with their clients, both exposed to the same threats. In this context, Diana questioned the very capacity of the Arab therapist to treat a client when both inhabit the same existential state of anxiety:

"We are all living in trauma, you feel how much you try and want to treat, but at the same time you also need treatment. The client and I are in the same place, do you understand—theoretically, how am I supposed to treat him?"

Manar elaborated on the effect of crime in Arab society on the therapeutic space, connecting it explicitly to the political context:

"Listen, when we talk about crime in Arab society, we can't ignore the political context—beyond the institutional discrimination we discussed, there's no doubt the state doesn't take responsibility for the rampant crime here. Now, this doesn't affect me only on a personal level, it affects the treatment processes too. For example—as a social worker I feel constant insecurity, I'm busy with clients' problems, but I'm worn down by the tension of exposure to crime—it worries me and stays with me all the time—at home, at work, even at the coffee shop. You sit there and you're tense because you don't know who and when might shoot you because you were in the wrong place at the wrong time."

4.2.4 Reactivation of Historical Collective Trauma

The most significant sub-theme to emerge from the analysis concerns the reactivation of historical collective trauma among participants following the events of October 7th and the subsequent war on Gaza. Since the war began, participants described a complex reality in which they live and work under an intensified emotional burden. According to their accounts, the war stirred difficult feelings that they were forced to confront daily—helplessness, despair, worthlessness, and anger flooded them in particular.

Many participants described the feelings that accompanied them since the war began, and which weighed on them especially heavily. Renin described this in her own words:

"You get up in the morning, another morning, you start your day with the news, you want to know what happened, what took place during the night. And then you see the Palestinian children screaming, running, even trying to escape—it's not that they really succeed. You feel the helplessness, mixed with a lot of anger about what happened and what's happening. You can't do anything, except for tears you can't escape. And then you have to get dressed, cover your face with a thick layer of makeup so no one sees that you've been crying."

Nahed, who works on a mixed team of Jews and Arabs, raised the feeling of transparency that accompanies her at work:

"You come to the office and try to act as usual, as if nothing is happening, as if you're in a bubble—shocking events are happening outside the office walls. Everything

here is pretend. As if we're a team, as if we're fine, as if we care about one another, but that's not true—it's a performance. I can't come to the office and share with my Jewish colleagues about the bombing of the hospital in Gaza, I can't share with them what's being done in their name there, they don't want to hear it either. It's clear. Their children are doing this, their partners—so who am I to come and unsettle them? I stay silent and continue my pretense, and they continue theirs."

Asked what might happen if Arab employees were to share their experience openly, the answer was nearly uniform among participants, who described a lack of trust in the system, in colleagues, and an unspoken demand for silence. Murad described this in his own words:

"You see what's happening, we all see what's happening, over nothing the police arrested the teacher who posted a TikTok video of herself dancing, over nothing they arrested Abu Amna, we all know it, people were fired from their jobs because they said children and innocents shouldn't be harmed. The Jews themselves are silent, so what do you expect from the Arab? The system works against you here, your colleagues are against you too. So you swallow it and stay silent. Just like our grandparents swallowed the sword in 1948 and stayed silent, because if not, they would have paid a heavy price."

Nahed detailed the price at stake:

"In the past, in 1948, they simply killed people, the silencing was thunderous. The silence today is also thunderous, you feel all eyes on you, your livelihood is threatened, you yourself are threatened, with all the weapons distributed here you're not safe, no one is safe, you might pay the price with your livelihood, your citizenship, and even your life, so you stay silent, or you are silenced."

Despite this weight, several participants located a countervailing source of strength precisely within their sense of professional mission. Murad articulated this as a moral imperative:

"We social workers don't have the privilege of despair, most of us entered the profession in order to change society, to promote equality and social justice. So you can't close your front door and say this isn't my responsibility. It is—it's all of our responsibility, and as someone who has taken on the task, you have to see it through."

For Sameh, the response to the trauma facing Arab society lies in strengthening one's sense of mission and service to the community:

"In my view this field is a mission, today I serve my society and my town, I try to give as much as I can, to give my best in order to advance my society and my village. True, it's very difficult in the shadow of the crime we deal with day to day—as private individuals and as professionals, hundreds are murdered and thousands of children orphaned—what strengthens me is my faith in the mission I'm carrying out here, especially in these circumstances."

In summary, participants described a complex socio-political reality within which they operate as therapists inside a community grappling with discrimination, lack of recognition, violence, crime, and a sense of abandonment. This struggle occurs on both the personal and professional level—as members of Arab society and as professionals. Across participants' accounts, the importance of a sense of mission emerged as a central source of strength for continuing therapeutic work under these conditions; this and other protective resources are examined in depth in a companion article.

4.3 Community Proximity and Therapeutic Boundary Complexity

The question of whether therapists work within or outside their own communities generated nuanced reflections on therapeutic boundaries, professional exposure, and self-efficacy.

Working within one's own village was described by many participants as enabling deep emotional and cultural connection, but also entailing high personal exposure. Murad noted:

"I try to do everything I can to promote my society and the town I belong to. Working within the village brings many challenges but also many opportunities that mostly ease the treatment process—when I know the family, its background and its connections, I see the problem more systemically and try to contribute to the treatment process through a more ecological approach. Being a resident of the village gives me that ability."

Naama spoke explicitly of the sense of belonging that drew her back to her home village:

"The sense of responsibility and belonging is the factor that brought me, after ten years, to return and work in my village. I know the local culture of the village and I

understand the dynamics between families, how to approach each one, and that's what makes them [clients] want to be in touch with me, because they know I know them and the environment we're in—it removes a lot of walls."

At the same time, several participants described the burden of expectation and lack of separation that in-community work entails—geographic and social proximity that creates community pressure toward involvement exceeding the professional role, and makes it difficult for the therapist to create a "clean space" free of external influence. Renin described this challenge:

"Expectations are very high [from clients]. Sometimes even things I can't do, they expect me to do because I'm from the village and from the neighborhood. They come to me and say—maybe you know people who can help us, you know and live our pain."

Samira added a further layer, describing how exposure to her community's stories and struggles gradually changed how she perceives its members:

"You know, in our profession, it's hard for a girl from the village to work there, she's exposed to a lot of things—distress, stories, and traumas—and then she begins to see people differently. She begins to know things she wasn't supposed to know as a resident of the village. It was hard for me in this respect, especially at the start of my work."

Conversely, for therapists working in other towns or regional clinics, "strangeness" is perceived as a resource that guarantees confidentiality and enables work on sensitive topics. In their view, the advantage lies in anonymity and assurance of confidentiality, as clients who fear community judgment or exposure of their secrets within their own town prefer to turn to a therapist outside their communal circle. Sahar explained the mechanism that helps clients open up to therapists who do not live in their town:

"The people who come to us share more when they understand that I'm a stranger [not a resident of the same town]. They think this person came to help me and will maintain absolute confidentiality. The client feels comfortable and can share everything comfortably without fear."

Beyond this, interviews revealed that the preference for a therapist who is not a resident of the same town is rooted also in the content of the conversations themselves. As clients wish to raise topics considered socially and culturally taboo—such as sexual

orientation, abortion, or infidelity—the "outside" therapist is perceived as someone who can grant legitimacy without fear of religious or social judgment. Ahlam described this:

"They [clients] think in their heads that if I go to a religious therapist, it's like going to a sheikh who will issue a religious ruling. All the cases of sexual assault or homosexuality are an example of this—they prefer to go to someone outside their social circle, someone they can talk to without feeling discomfort or fear of exposure and breach of confidentiality."

Naama added the need clients feel for legitimacy around taboo topics:

"It's easier for them to go to a therapist who isn't even Arab, because practically, it will grant legitimacy to all their conflicts, all their confusion, all their thoughts and all their feelings, without feeling guilt."

4.4 Manifestations of Secondary Traumatization: Psychosomatic, Affective, and Cognitive

All participants described experiencing consequences of secondary traumatization, manifesting across psychosomatic, emotional, and cognitive dimensions consistent with the symptomatology identified in the STS literature (Figley, 1995; Ogińska-Bulik et al., 2021).

Psychosomatic Symptoms. Most participants reported somatic manifestations of post-session stress including headaches, elevated blood pressure, gastrointestinal distress, and bodily restlessness. Arin described arriving home in a state of physical dysregulation:

"When you come home, you are no longer yourself. You are agitated, stressed, and you have a headache and all kinds of pain in different parts of your body. I start to think, why does my stomach suddenly hurt? Why is my blood pressure so high?"

Manar testified to acute physical restlessness following exposure to a case in which a client had been threatened with murder by her partner:

"When I got home I felt a very great restlessness, real restlessness. I couldn't sit still. It wasn't only on a mental level, it also affected me physically. I couldn't stay in the house, I gathered the children and we went out—I simply couldn't stay with the thoughts and my body in those moments."

Emotional Numbing. A second group of participants described emotional numbing—the progressive loss of capacity for emotional response to traumatic content. Sameh reflected:

"Today I can tell you that, as someone who has been exposed to so many traumas, I feel nothing—I am in a kind of emotional numbness. If a murder happens in the village, I am not moved by it."

Diana shared a troubling experience of numbness in the presence of an offender under her care:

"When I prepare his [the client's] treatment plan, I look at myself and recognize that I don't feel anything. In this recent period, I've reached a point where there's no emotion, and that's been really hard. I can't manage to connect to my feelings when I ask him how and why he killed her."

Intrusive Thoughts and Boundary Dissolution. The difficulty of maintaining psychological separation between professional and domestic life was reported by nearly all participants. Renin described the persistence of intrusive worry after the workday ends:

"When I get home, the thoughts don't let go—I keep thinking and thinking about the girl, about what she told me, about the distress she's in and about possible solutions. I felt like something was sitting on my chest, struggling to breathe and to communicate with my children. I'm present physically, but mentally I'm deep in worry about the girl."

Ahlam described difficulty sleeping due to emotional involvement:

"That case robbed me of sleep, I can't manage to sleep, it stays with me emotionally. To this day I haven't managed to resolve it, I come home after exposure to one client's trauma and I struggle to sleep and I have tears in my eyes all the time."

Murad noted that the tension generated by trauma exposure harms his personal wellbeing and dissolves the boundary between work and home:

"It mostly affects me through worries about the future. I come home with thoughts, with worries about clients, with calls I need to make to the institution. It follows me even when I'm already at home. The boundary between work and home, for the most part, simply doesn't exist."

Most participants reported that exposure to stories of injury and violence from clients generates heightened anxiety regarding their own children's safety. Renin described how completing a training course on sexual abuse intensified her anxiety as a mother:

"In this recent period, after I finished the course on treating sexual abuse, I started to notice and think about things I hadn't thought about before. I would come home from the course and start yelling at the children, why are you playing there? Don't go here or there. My anxiety rose and my fear of harm to them intensified."

Diana described heightened vigilance stemming from cases she is exposed to in the treatment room:

"Since I started being exposed to clients' problems and traumas, I started to be afraid, to worry. I became someone who worries all the time about her children, that God forbid nothing happens to them, that they don't go through what my client went through—the feeling is constant preoccupation."

In summary, participants described being exposed, in the course of their work, to difficult traumas that clients bring into the treatment room. These traumas generate stress, tension, intrusive thoughts, and discomfort among many of them, though some described emotional numbing. The strategies participants use to cope with this burden—including collegial humor, peer support, and religious, familial, and community resources—are examined in a companion article addressing resources for overcoming secondary traumatization.

5. Discussion

5.1 Shared Trauma as a Theoretically Novel—and Dynamically Activated—Configuration

The concept of "shared trauma" that emerges from this study—wherein therapist and client inhabit the same violent, marginalized, and institutionally neglected social environment—constitutes a meaningful theoretical contribution to the STS literature. Existing models, including the CFR framework, assume a structural differentiation between the therapist's position of relative social safety and the client's position of vulnerability. In the Arab Israeli context, this differentiation is substantially eroded. Therapists are not merely exposed to their clients' trauma narratives during therapeutic hours; they live within the same trauma-permeated social field around the clock.

The findings presented here reveal, further, that this configuration is not static but dynamically activated by collective political events. The reactivation of historical collective trauma following October 7th and the war on Gaza demonstrates that the shared-trauma condition intensifies sharply during periods of national crisis, generating an acute additional layer of exposure that operates independently of, though in interaction with, routine clinical exposure. This finding necessitates a revision to the CFR model's exposure-to-suffering variable, which currently treats exposure as a relatively stable function of caseload and clinical content: the present data suggest that exposure must instead be modeled as partly exogenous to the clinical encounter, fluctuating with the political and historical trajectory of the therapist's own community.

Compounding this dynamic, the phenomenon of professional silencing within mixed Jewish-Arab teams—articulated by participants through the historically resonant metaphor of "swallowing the sword," recalling 1948—reveals an additional psychological cost specific to minority professionals working in majority-integrated institutional settings during periods of national conflict. This silencing represents a distinct stressor, separate from both clinical exposure and structural discrimination, arising from the enforced suppression of political and emotional expression in professional spaces that are ostensibly collegial but function, in participants' accounts, as sites of enforced neutrality that fall disproportionately on the minority professional.

We propose the term "shared trauma reactivation" to capture the process by which acute national-collective events reopen and intensify the baseline condition of shared trauma described above. This construct has two components: an internal component, involving the flooding of feelings of helplessness, grief, and anger tied to collective historical memory; and a relational component, involving the professional silencing that occurs specifically within mixed-identity institutional settings during such periods. Future research should investigate the bidirectional and cyclical nature of this reactivation process, and examine whether analogous dynamics occur among therapists from other historically traumatized minority communities during periods of collective crisis.

6. Conclusions and Implications

6.1 Theoretical Contributions

This article makes two primary theoretical contributions. First, it introduces the "shared trauma" configuration as a theoretically distinct form of STS exposure that arises when therapist and client share the same sociopolitical context of marginalization and violence, requiring revision of existing models premised on structural differentiation between helpers and helped. Second, it identifies a temporal, event-activated dimension of shared trauma, whereby national-collective crisis reactivates historical trauma and generates a distinct pattern of professional silencing within mixed-identity institutional settings. A companion article extends this analysis to the culturally specific resources and self-efficacy mechanisms through which Arab therapists withstand these pressures.

6.2 Practical Implications

Two recommendations emerge from these findings with particular urgency.

Institutional and policy reform. Addressing secondary traumatization among Arab social workers in Israel requires addressing its structural preconditions: inadequate mental health infrastructure in Arab communities, cultural non-adaptation of institutional therapeutic models, and the systemic silencing of Arab professional voices within mixed professional systems.

Crisis-specific support infrastructure. In light of the findings on shared trauma reactivation, organizations employing Arab therapists should develop dedicated emotional-processing spaces activated specifically during periods of national-collective crisis, distinct from routine mixed-team supervision, alongside institutional mechanisms that explicitly recognize and legitimate the political and emotional voice of Arab professionals during such periods.

6.3 Limitations and Future Directions

This study's qualitative design and specific population limit generalizability. Future research should examine shared trauma configurations—including their reactivation dynamics—in other conflict-affected or structurally marginalized contexts; develop quantitative measures for the shared trauma reactivation construct proposed here; and investigate longitudinal patterns of STS development among Arab therapists across career stages and across cycles of national-collective crisis.

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