Secondary traumatization: fate or challenge for healthcare professionals

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Summary
Secondary traumatization is a phenomenon that occurs not just in psychotherapy, but may happen with any healthcare professional (HCP), in particular with those who engage empathically with their patients. Secondary traumatization is due to experiencing the explicit and implicit stories of patients struggling, often unconsciously, with experiences of violence earlier in life, and the consequences of these. If not recognized and properly addressed, secondary traumatization may lead to burn-out, disillusionment and disability to work as a HCP. If addressed in a constructive way, the first symptoms of secondary traumatization may be seen as a challenge, which can lead to an improved quality of one's professional and personal life. Crucial in this for a HCP is a developmental process to accept the presence of violence in its many forms and the consequences for the health of their patients and of themselves.

Keywords: secondary traumatization, violence, burn-out

Communication between a healthcare professional (HCP) and patient happens (at least) on two levels: first on the concrete, visible, objective level (verbal or physical). Most of the time we are aware of what we are doing or saying on this level. Secondly, on the invisible, immaterial, subjective level (feelings, moods, projections or expectations). Most of the time we are not conscious of what we are communicating on this level. But communication on the second level happens all the time. So, the HCP as well as the patient is present in the encounter with both the conscious and the unconscious level.

Most HCP's become a HCP because they want to help human beings or because they feel some kind of compassion for the suffering of people. The relationship between HCP and patient is the means by which one can help others. Based on my experiences of the last 20 years of guiding people (with different kinds of questions or problems) in healing processes, my experiences as a teacher and supervisor of healthcare professionals, and as a scientist, I am convinced of the fact that this relationship between HCP and patient can either promote or block healing processes of patients, depending on the quality of the relationship (1). And this depends on the degree of awareness the HCP has about his or her subjective communication and on his or her taking responsibility for that.

1. The healing aspect of the relationship between HCP and patient

Since the time of Carl Rogers, the term 'empathy' is well known. Although Carl Rogers worked as a psychotherapist, his concept of empathy applies for every relationship in the helping professions, like the relationship of medical doctors, especially general practitioners (GP's), physiotherapists, and nurses with their patients or clients. Much is said about 'empathy'. It is not simply 'feeling' the feelings of another person or 'sympathizing with' someone else (2). Rogers called it one of the three conditions which have to be present in the helping person, in order to create a climate that promotes growth or healing of the patient: genuineness, unconditional positive regard and empathy. In one of his last books before he died he made a last attempt to describe the concept of empathy:

"When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. This kind of sensitive, active listening is exceedingly rare in our lives. We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know."(3)

I think all HCP's know moments in which one has experienced this kind of relationship and these moments are precious when they happen in your work. Those are the moments in which you experience 'a real contact' with your patient, in which he or she is able to share with you (with or without words) some painful or moving life-experiences or important questions. Those are the moments which give meaning to your professional life. But these are also the moments that you come in contact with and experience the patient's feelings, which are part of these shared experiences. Feelings of pain, loneliness, fear, despair, anger or horror. Sometimes the patient shares these feelings openly with you, but often this person is not or only partial aware of these inner feelings, because they are (in the words of Rogers) 'below the level of awareness' and 'inside their private world'.

So next to the experience of 'having a real contact', these encounters can bring a HCP also in contact with all kinds of feelings, which then evoke reactions within the HCP: varying from withdrawal (taking distance of the other by starting to rationalize what's happening) to becoming overwhelmed by one's own emotional reactions (feeling uncertain and vulnerable and not knowing anymore what to do). Either way, the HCP will not be able 'to listen with real understanding, true empathy'. And this has consequences for the quality of the relationship: it will, at the very least, not promote the healing process of the patient. And, if this happens more often, it shall have also negative consequences for the HCP in the long run: one will lose more and more the experience of meaning in being a HCP and one will become burnt-out.

And that is a pity, because this happens in particular to those HCP's who make contact with their patients or clients in an empathic way. Is it then not possible to work with empathy and compassion, with an open heart? Or do HCP's have to learn to deal with these kind of reactions in oneself and with the experiences that provoke them in a way that they do not have to shut down their heart and empathic abilities.

2. What is happening with the HCP when one is in an empathic encounter?

In the field of psychiatry and psychotherapy, this question has been important since Sigmund Freud (4, 5). In his time, a century ago, the concepts of 'transference' and 'countertransference' were developed. And because these concepts have a profound meaning in the therapeutic relationship between a psychotherapist and a client, since then quite a lot of research on these matters have been carried out. Now we can easily say: "That happens only in very special therapeutic relationships. It has nothing to do with the work of a medical doctor or a nurse." That is not true. The same dynamics, which take place in the relationship between a psychotherapist and his client, take place in every helping relationship, even though the purpose of the relationship is not psychotherapy.

By transference is meant: the projections of intrapsychic processes of the patient towards the HCP, which one is not aware of (4). I will give no further attention to this item, because my focus is on the process of the HCP.

2.1. Countertransference

Pearlman and Saakvitne defined countertransference as having two components: the affective, ideational, and physical responses a therapist has to her client, his clinical material, transference, and reenactments; and the therapist's conscious and unconscious defenses against the affects, intrapsychic conflicts, and associations aroused by the former (4).

An example of this phenomenon is the burnt-out GP who saw in every patient who visited her a pityful burnt-out person. She told many of them to take a sick leave for the coming months, gave them antidepressive medication and gave them our address for counseling.

We do counsel many people with symptoms of burn-out and she knew that. So some of these people actually came to us and told their story. It struck us that those persons were not really burnt-out and that staying home from work or taking drugs were the last thing they needed. Some months later this GP called for an appointment for herself, because in her words: "she noted that she was beginning to have some signs of burn-out".

Countertransference is said to have to do with an activation of unconscious and unresolved intrapsychic problems in the HCP while encountering a certain group of patients. In contact with them, specific problems which have to do with her own personal history are in a way activated (4).

Another example of this is the GP, who asked for supervision because he was in a crisis concerning his work. He had been a GP for several years and until two years ago, he had enjoyed his work very much. But since then he gradually began to react towards certain patients: he called them 'nagging victims'. He became more and more irritated in his work. He said: "they come into my room, throw their problems on my table, feel very sorry for themselves and demand that I solve their problem. But I can not help them. Let them solve their own problems". In the meantime he was very kind to these people outwardly, but he was boiling inside. And when he came home, he reacted out his anger and frustrations on his wife and children. After a while he decided to stop working as a GP. He left his practice and took a job in a center for disabled people. It is amazing how people can react when they are not acknowledging their inner signs. Because, within a few months he was desperate: he felt disgust towards the disabled persons, he could only see them as 'nagging victims'. That was when he came to me for supervision. In those supervisions it became clear, after much reluctance of him to admit it, that he had been sexually abused by a neighbour, between the age of 12 and 15 year. He had never talked about it. He felt deeply ashamed and was very angry on himself, because he had decided (as most victims of sexual abuse do) that it was his own fault. So he had to go on and not feel sorry for himself. He went through a healing process in which he could acknowledge that it had not been his fault, and that he really was a victim. That he had been wounded as a boy, in his body, and also as a human being, in his soul. In that process he learnt to open his heart towards the victim in himself, who yearned for attention and acknowledgement and then he could also open his heart towards his patients. Now he is working again as a GP and he enjoys his work very much.

These are two examples of countertransference. But the same kind of subjective reactions from the HCP towards his or her patients can also come as a result of dealing or working with traumatized people, without any specific unresolved issues of the HCP.

2.2. *Secondary or vicarious traumatization*

The phenomenon of secondary traumatization was first recognized in the field of traumatherapy. Since the 70's of the last century the negative effect of exposure to violence on the psychological and somatic health and well-being of a person has been recognized and taken seriously. Since then different kind of therapies for victims of violence have been developed. What became clear in the following years, is that working with victims of violence (like physical, sexual or war-violence) had a deep impact on the therapists themselves. This was called: compassion fatigue, secondary traumatization or vicarious traumatization (4-9).

Although this process was given different names, the core of what is happening is the same. A good description of this process was given by McCann and Pearlman in 1990. They called it 'vicarious traumatization':

"It refers to the cumulative transformative effect of working with survivors of traumatic life events. This means that in the long run a negative change is taking place in the inner experience of the therapist as a result of empathic engagement with the client's traumatic stories."(6)

This change takes place as a reaction to listening to the often painful or horrific stories of violence that the other has experienced, been witness of or has been doing to others (like the stories of Vietnam-vets). Just by listening in an empathical way, one can become traumatized.

Although this concept is more common knowledge for psychotherapists who are working with traumatized people, it is relevant for all trauma-workers, and also for HCP's in general, especially those who engage empathically with their patients and their life-stories. Because, although a HCP is not therapeutically working with another person around experiences with violence, most people have had experiences of violence in the course of their lives and subsequently become traumatized to some degree in a way that has an impact on their daily lives.

3. Encountering violence in daily practice

When talking about experiences of violence, we usually think of physical or sexual assaults. But also abuse of power, humiliation, manipulation, emotional blackmail, verbal violence, threatening, teasing or bullying, neglect of affection or care, and such, are forms of violence that may lead to traumatization in the long run with physical, psychological and/or relational complaints and problems. Many healthcare professionals will meet people with these complaints and problems, unaware of the underlying dynamics (10).

Based on my daily work as a counselor for clients who have experiences with different forms of violence in their past or present life, and as a supervisor for HCP's who have problems within their work, I have come to the following working-definition of violence:

Violence is the force that damages or tries to damage the integrity or entity of a person as a whole or parts of one's system (like the body or the will of a person) (11).

Violence creates painful wounds, sometimes physical, but always also in the inner world, in our basic experience of being a unique individual. In reaction to these existential experiences of pain, surviving strategies are formed, meant as protection. But later in life these strategies become restricting and they start to cause physical, psychological and/or relational problems (9-12). And when that happens, people start to look for help, and often they then go to their GP. They usually have 'forgotten' their original wounds, or they will not make the connection between their complaints and their history of violence. They will tell their complaints, but they take with them their life-history, which can come to the surface in the encounter, especially when one meets an empathic HCP who is really interested and asks the right questions. Or they can have very strong reactions, when the HCP wants to examen the patient's body, which can be very upsetting for the HCP.

Many patients have complaints which relate to experienced violence, in the past or in the present. Looking at statistics of prevalence of violence, more than 90% of all people have had one or more violent encounters during lifetime (13-15). And next to this, it is clear that domestic violence is happening much more than violence on the streets (15-17). With domestic violence I mean all interpersonal violence done by family members. So this means violence between partners as well as violence to children. Particularly domestic violence can have many faces: varying from physical and sexual assaults, to verbal, psychological or emotional violence. Most of the time domestic violence is a mixture of all. Next to that, domestic violence is occuring in all levels of society.

So HCP's, also those who are working in the primary healthcare, like GP's or community-nurses, have many contacts daily with people who have been involved in violent interactions, without being aware of it. And not only victims, but every act of violence creates a victim and a perpetrator. So every HCP also meets many perpetrators. Often persons of whom you can not believe they did this.

So, every HCP encounters, unconsciously or consciously, a lot of violence in his or her daily practice. You can not ignore the presence of violence in daily life. And that hurts and provokes all kinds of inner reactions, which can easily lead to becoming too involved (overidentification with the traumatized people one meets) or to becoming distant (cynical, and in avoiding real contact with one's patients). These are signs that a process has started, which can easily lead to a secondary traumatization of the HCP. And HCP's who have unresolved experiences of violence in their own life histories usely will get even stronger symptoms of secondary traumatization.

I prefer to use the term 'secondary truamatization', simply because in the dutch language there is not a good translation for the word 'vicarious'.

4. What is happening in this process which can lead to secondary traumatization?

In the encounter with the explicitly or implicitly told stories there is a painful confrontation with the reality of life. The core of the problem of secondary traumatization is that an inevitable change takes place in the basic inner mental frameworks or belief systems. And this change has an impact on how one experiences life, which has consequences for the quality of one's professional and personal relationships (4, 6, 8).

Said in another way, in confronting many patients with implicit or explicit stories of violence, the mental framework of the HCP falls apart. One's belief systems, assumptions or expectations about life or about one self, are different from the reality the HCP experiences. Because of that one changes one's views about oneself (from "I am a good doctor" to "I am a bad doctor because I can't help or prevent all this"), about other people (from "all people are essentially good" towards "everybody is a potential violent offender" or "all men are monsters") and about spirituality or one's view of the world (from "I believe in a meaningful world" to "it is hopeless").

What I notice in my work as a teacher and a supervisor of HCP's is, that behind these assumptions, there is a deeper level of basic assumptions or belief systems about the existence of violence, which most HCP's are not aware of. These are assumptions like: "violence is an aberration, it should not be there", "normal people (like us) do not become violent", "only sick or abnormal persons are the violent ones", "there can be a world without violence" and "if you do not protect yourself against violence, it will destroy you".

Precisely these basic assumptions, which gave a sense of safety and security, turn out to be untrue. The reality of life is quite different: violence is part of everyday life, also 'normal' looking people turn out to be violent and if that is true for those 'nice' looking people, what does that say about oneself? Those are thoughts that not everybody wants to be confronted with.

4.1. Fate or challenge: secondary traumatization or transformation

At this point there are two roads that can be travelled. One can see the reality of violence as only dangerous. Then one will try to protect oneself against it. Or one can see it as an opportunity, a challenge, to learn to stand in this reality. Most of the times one chooses out

of unconscious patterns, not aware of having a choice, unless one gets symtoms of secondary traumatization and wakes up and asks oneself: what is happening? This is often the moment one starts to look for help.

5. What are symptoms of secondary traumatization?

This is a slowly growing process, in which one gets more and more symptoms. It may result in becoming afraid, suspicious, in having nightmares, or being hyperaroused at night and not being able to sleep (4, 6, 8,11). Basically there are two patterns (5, 8). One pattern is overidentifying with patients. This means not being able to say 'no', being available all day and all nights, not being able to stop thinking about certain patients and at the same time feeling guilty for nor being able to help them and thinking what one could have done better. The second pattern is becoming very cynical about patients and about the world. Becoming hostile, angry towards everybody who tries to come too close: also towards one's own family members and friends. Giving others the message: 'leave me alone'.

If not recognized and dealt with, a negative change takes place in the long run, in the sense of how one experiences 'life' in general. Because it affects one's feelings, experiences of people or of oneself, one's relationships with other people, as a HCP but also in private life. One is no longer able to have loving relationships and one can become overconcerned or overprotective towards one's own children.

I will give an example of myself (1, 11). In 1990 I started to work with people who had experienced incest and other forms of violence in childhood. Guiding them in healing processes. In the beginning I often shared what I experienced in the encounters with my colleagues in the institute and especially with my husband. I found what I heard often very shocking. But gradually I began to share less. I reasoned for myself that I should be able by now to handle those stories and the feelings which were evoked by engaging in those often very profound healing processes. In fact I often could not put myself to give words to what my clients confided to me. It was so shocking! And I thought I could not share that with others, because it would be too much for them, they could not handle that! So I withdraw more and more into myself. After 3 years I started to get serious problems. I often felt very cold and depressed and I did not want to talk about it. I became burnt-out. In that time I got ill and during those days, I started to get nightmares. Several. But the worst was the one in which I was walking over a battlefield, where a very violent battle had taken place. The fighters or soldiers had gone on and I was walking there. It was the end of the night, the sun was rising and I saw many and many victims lying there. Some were dead and some were badly wounded. Grown ups and children. Some were crying and some were just staring silently. I panicked while looking at all those wounded persons. This was too much. There was so much needed, how could I possibly help all those people. So I sat down and felt very powerless, cold and depressed. Then I woke up, crying.

This nightmare opened my eyes and I started to talk more about what I was experiencing and I decided to have supervisions. And I am very glad I did. It helped me to find my way in dealing with all the painful and shocking information that people shared with me. Nowadays I still work with people with different kinds of experiences of violence and I enjoy my work, in the sense that I notice that I can really be there for those people and guide them in their healing process.

But if one does not make a decision to take one's problems seriously, secondary traumatization ends in serious burn-out symptoms or even in symptoms of PTSD. This often leads to quitting the job, because of severe symptoms of burnout, because of having lost the sense of being an effective helper or because of a feeling of demoralization and so

called ‘soul-sadness’, which characterize the spiritual damage of vicarious traumatization (4).

5.1. Denial and avoidance promote the process of secondary traumatization

Being in contact with a person who is in pain or in despair, evokes reactions in a HCP who works in an empathical way. Reactions of compassion, but also of anger about what has happened, etc. Such reactions are normal, but they can make a person uncertain, or sad. If one looks at those reactions in a negative way, one wants to get rid of them, by fighting them or denying them. The best way to do that is by closing one’s heart in the encounter with patients as a protection, which indeed is often recommended: learn to work in a distant professional way. By doing this, one does not have to face reality, and one tries to cling to one’s basic, idealistic, assumptions about life and about violence.

This is an (often) unconscious attempt to escape the encounters with the implicit or explicit stories of violence, afraid of what might be the consequence of that. But the stories and experiences of the patients will not stop and in order to keep them outside, one has to disconnect more and more from reality. This means one has to close off one’s own heart more and more. By doing that one will experience less and less meaning in working and less and less vital energy (19).

The way this works is that one is using patterns of denial (‘domestic violence does not happen with the patients in my practice’), or of avoidance (‘not asking about it: as long as one does not know, it does not exist’).

In working with persons with an acute stress disorder based on experienced or witnessed violence, it is known that avoidance and denial are factors that can lead to a chronic stress disorder (20, 21). This applies not only to the victims of violence, but to everybody who engages emphatically with his or her clients and their stories of experienced violence. Especially this behavior of denial and of avoidance, of not wanting to know what is really happening, starts the spiral downwards.

This is a pity because these healthcare professionals are often the ones who chose a career in healthcare out of a strong sense of compassion for people. And it is not necessary! It could only happen, because one was not able to deal with one’s experiences in a healthy way.

6. Loss of innocence promotes the process of transformation

The main characteristic of the road, that can lead to a transformation, is that one sees the confrontation with one’s basic mental frameworks and belief systems not as a danger but as a consequence of working with people and that one chooses to go into a process of discovery, in wanting to learn to stand in this reality of life. That does not mean that one experiences less pain, anger, despair, etc, but that one sees those experiences as a challenge, which is part of the job, and that one wants to addres them in a proper way.

This means going through a process of what I call ‘the loss of innocence’ (11, 12). A process of confronting oneself with the restrictions of certain basic assumptions and seeing the necessity of letting them go, because they do not reflect reality. This is not once, but again and again. And that is not an easy process, it primarily gives the feeling of loosing grip, which is scary. But by doing so, one starts to feel space inside to allow different kinds of experiences to be present , like one’s fear for violence, one’s pain in seeing that this is reality. This starts a process of learning to accept reality as it is.

Instead of denial or avoidance, this means that the HCP learns to investigate one's own experiences which are evoked in or because of the encounters with patients. Investigating them not in a mental way (trying to find the answer why this could happen), but by learning to allow the experiences to be present and in relation to those experiences reflect on them: what they have to tell and by doing so become aware of what they mean for oneself. So by developing skills of self-awareness and self-reflection.

In the past years I have supervised a GP in this process of learning to deal with violence in her work. She learnt a great deal and I did not see her for several months until she recently called for an appointment. She told me that she had missed an illness with an old lady of 90 years old and that she had never done this before. When she was on holidays, another GP had diagnosed it. I asked her if she knew what had been in the way and she told me that she realised afterwards that she had not really listened to what the woman had said, because she had not made real contact with her. I know this GP very well and she is an accurate and compassionate doctor. This was the opposite of what she normally did. She told me that she felt a strong resistance towards this lady, because she was so very bitter about all the painful things she had experienced in her life, blaming everybody for that and this GP often felt manipulated by her. In fact, this woman had a habit of being very destructive and emotionally violent towards HCP's. Connecting with the resistance, the GP felt a lot of anger inside! About what? She said: "About the fact that some people can be so very destructive to themselves and to others, and I can not stop it from being there. I don't want it to be there." 'It' being the fact that patients could be very violent.

In the past period she had learnt to see and deal with the reality of how violence can traumatize people. She had let go of her assumption of an ideal world in which there is no violence. She was in general more in contact now with her patients, she could handle much better the stories of traumatized victims and the quality of her work had improved a lot. But during our meeting she became aware of another assumption: yes she knew that violence was part of reality and people could get hurt very badly by it, but now she had to confront the fact that she had taken as a belief that victims were only pitiful and that they could not be destructive or violent persons themselves. Instead of being angry, I asked her to relate to this reality and take serious what she experienced with that. She said she felt a lot of pain, connected to the letting go of another idealistic view of the world and she could experience now that she had been hurt many times by this woman. She also felt relief and she decided to go back to this woman , being aware of and accept her in her bitterness and manipulating behavior, see also the pain of this woman's life, which she had not been able to deal with, and make real contact with her without taking her reactions personally.

6.1. Professionality of the heart

So by dealing with the symptoms of the process of secondary traumatization in a constructive and healthy way a transformation can take place.

By acknowledging the reality that every compassionate HCP will at some point in his or her professional career have to deal with signs of secondary traumatization, the path that leads to quitting one's job in a desillusioned way can be prevented. By seeing it as an occupational risk, as an inevitable part of the work of a HCP, one needs to learn to deal with it in a constructive way. And by doing so it is part of a process of inner development that will make it possible for the HCP to be better able to help people deal with violence and traumatization.

And it leads not only to an improvement of one's professional life, but also to one's personal life, because one is again able to participate in loving and meaningful relationships.

The core of this process is that the HCP learns to be in contact with an open heart, so that one is able to experience more. And next to that, that one learns to relate to those experiences in a healthy way. In our institute we call this professionality of the heart. Next to staying healthy oneself, the value is that the HCP is able to be more present for the patients and their stories and, by doing so, creates a space for the patient to allow his or her experiences to be there. In this space, the HCP can investigate together with the patient what he or she needs in regard to those experiences (2, 12).

Nowadays this inner development often starts when the HCP asks for help, because of the fact that he or she is having problems with functioning as a professional. If the symptoms are recognized by the HCP and the supervisor or therapist. Because secondary traumatization is often seen as something that is only happening to psychotherapists, it is rarely recognized for what it is when happening to HCP's like GP's and nurses, which can have serious consequences.

7. Recommendations.

I end this article with two recommendations. One is to the persons who develop the curricula for medical students, for doctors in training for GP's or other specialisms and for paramedical students (like nursing). The recommendation is to develop programmes to teach students how to deal with violence in a healthy way, tell them about the process of secondary traumatization and teach them to take one's experiences serious by teaching them skills of self-awareness and self-reflection.

My second recommendation is to develop post-doctoral programmes for functioning HCP's. Looking at the discussion of the last two years about the need of routinely asking patients about domestic violence for instance by GP's or community-nurses, and the conclusion that it is done not often enough, is not solved by simply teaching HCP to ask the right questions (17, 22, 23). The real issue in my opinion is that many HCP's are afraid to go into relationship with traumatized persons, because they don't know how to deal with what they are told or with what they themselves will experience in those encounters. They need to get the opportunity to learn to deal with violence in a healthy way.

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