RESEARCH REVIEW

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Secondary Posttraumatic Stress and Nurses' Emotional Responses to Patient's Trauma

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ABSTRACT

Alarmingly high percentages of secondary posttraumatic stress have been reported in several nursing domains such as critical care and emergency nursing, oncology, pediatric nursing, mental health nursing, and midwifery. The purpose of this review is to examine and **describe nurses' emotional responses in the face of their exposure to patients' trauma.** Lack of understanding of the dynamics of trauma may limit nurses' ability to interact in a meaningful and safe way with patients and their families. Spirituality can be a precious compass in the long-term journey of resolving feelings of grief and loss at work and of building a strong professional identity.

Key Words

Compassion fatigue, Emotion work, Secondary traumatic stress, Self-care, Trauma

The concept of posttraumatic stress disorder (PTSD) arose in the wake of the Vietnam War (Trimble, 1985) whereas its formal introduction in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) came only in the 1980s. Despite criticism relating to the social and political power issues implicated in the medicalization of human suffering, research on the psychological impact of trauma and its treatment has flourished during the last decades (Stein, Seedat, Iversen, & Wessely, 2007; Summerfield, 2001; Yehuda & Farlane, 1995). Furthermore, interest has recently been drawn on the pervasive effects that PTSD may have on professionals who try to address the needs of traumatized individuals (Figley, 1999).

Secondary PTSD, compassion fatigue, and vicarious traumatization are the terms that are used almost interchangeably to describe the "cost of caring" for the traumatized individuals in nursing (Dominguez-Gomez & Rutledge, 2009; Meadors & Lamson, 2008) and other disciplines (Curtis & Puntillo, 2007; Figley, 1999). Indeed, nursing researchers report alarmingly high percentages of secondary PTSD in critical care nursing (Karanikola, et al., 2015), emergency department (Morrison & Joy, 2016), oncology (Quinal, Harford, & Rutledge, 2009), pediatric nursing (Meadors, Lamson, Swanson, White, & Sira 2010), mental health nursing (Lee, Daffern, Ogloff, & Martin, 2015; Mangoulia, Koukia, Alevizopoulos, Fildissis, & Katostaras, 2015), and midwifery (Beck & Gable, 2012).

Although the true magnitude of secondary posttraumatic stress still remains unclear due to methodological limitations and differences in study designs and instruments employed, professional training, organizational cultures, or organizational health care systems between countries (Beck, 2011; van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015), the risk of emotional distress implicated in working with traumatized clients has certainly been recognized.

THE DYNAMICS OF TRAUMA: CARING FOR THE PATIENT WITH TRAUMA AND HIS/HER FAMILY

Caruth (1996) described trauma as an "unclaimed" experience, an event "experienced too soon, too unexpectedly, to be fully known and … therefore not available to consciousness until it imposes itself again, repeatedly, in the nightmares and repetitive actions of the survivor" (p. 4). The experience of trauma actually leads to deep psychological injury at an unconscious level that entails loss of control, language, power, and self. Trauma is a wound that "cries out," a silent wound that is articulated through re-enactments. As a result, traumatized individuals are vulnerable to repeating past traumas and remain in a crisis without being able to regain control over their current lives. Getting to "know" their trauma overwhelms them emotionally to the extent of rendering its cognitive processing impossible. According to Caruth (1996), recovery from trauma entails that it is spoken in all its horror and violation to someone who can listen to it without being overwhelmed. To integrate trauma into their lives, traumatized individuals must find language and symbols to express the frustrations, helplessness, disempowerment, and humiliation they suffered. Fragmentation of identity caused by the rupture of trauma is healed through the construction of a narrative.

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Nonetheless, the prospect of conceiving trauma is intolerable. Furthermore, the recovery of traumatic memories may retraumatize the individual (Gabbard, 2000). This is why the National Institute for Health and Care Excellence (NICE) guidelines (2005) recommend to avoid single-session interventions (known as debriefing) during the first month after a traumatic event. But even later on, the recovery of traumatic memories does not constitute a goal of therapy. According to Gabbard (2000) when memories of trauma reemerge, they may disrupt the normally integrative functions of memory, identity, and consciousness. Dissociation constitutes a way of warding off negative affect. Such defensive strategies, however, narrow the individual's field of awareness and may partly explain why severely traumatized patients have a reduced ability to think reflectively about themselves and about relationship experiences. Therefore, professionals having a therapeutic relationship with severely traumatized individuals should focus on enhancing patients' ability to reflect on their relationships to other people instead of focusing on recovering memories (Gabbard, 2000).

NURSES' EXPERIENCES OF CARING FOR THE PATIENT WITH TRAUMA AND HIS/HER FAMILY

Pain, loss, disability, chronic illness, and failure to achieve relief from symptoms constitute trauma dimensions that nurses have to deal with in everyday practice. In the study by Mealer, Shelton, Berg, Rothbaum, and Moss (2007) on PTSD in intensive care unit, nurses described the situations triggering secondary traumatic stress. These included seeing patients die, patient aggression, involvement with end-of-life care, verbal abuse from family members, physicians and other nurses, open surgical wounds, massive bleeding, trauma-related injuries, care futility, performing cardiopulmonary resuscitation, feeling overextended due to inadequate nurse-to-patient ratios, and not being able to save a specific patient. Pediatric intensive care nurses also describe feelings of frustration accompanied by feelings of helplessness, especially when having to be involved in the resuscitation of extremely premature infants (Molloy, Evans, & Coughlin, 2015).

Maytum, Bielski-Heiman, and Garwick (2004) in a qualitative study of compassion fatigue in pediatric nurses describe the emotional stress that nurses experience as a result of working with traumatized children and their families. Participants described the challenging experience of sharing the emotions of patients. Reported personal triggers included crossing professional boundaries and having unrealistic expectations, whereas work-related triggers were lack of support from management and work overload. Similarly, Cook et al. (2012) described how deeply affected are pediatric nurses by memories of patient arrest or witnessing patient death, especially during the first years of their career. Participants in their study also expressed guilt about not feeling certain emotions that they felt they "should" be feeling at the time of a patient's death.

Oncology nurses are also repeatedly exposed to traumatic experiences while caring for their patients and are, therefore, prone to secondary traumatic stress (Quinal et al., 2009). Secondary traumatic stress is described as resembling PTSD but is triggered from exposure to persons who have experienced trauma and from giving care to such persons. Exposure to end-of-life issues, death, and cumulative exposure to patient suffering are described as precipitating factors to the development of secondary traumatic stress. The symptoms of secondary traumatic stress are described as including sleep difficulty, intrusive thoughts about patients, irritability, and a sense of a foreshortened future (Quinal et al., 2009). Least common symptoms of secondary traumatic stress were avoidance of people, places, and things and disturbing dreams about patients.

As regards nursing care at emergency settings, participants in the study by Wolf et al. (2016) described "being overwhelmed" by patient care as a source of moral distress, which in turn resulted in feelings of powerlessness, guilt, fear, anger, and frustration. Interestingly, nurses in this study found even more distressing feelings of powerlessness to make systemic changes in order to provide sufficient patient care.

Finally, two concept analysis studies of secondary traumatic stress and compassion fatigue (Coetzee & Klopper, 2010; Mealer & Jones, 2013) and a qualitative study on the latter (Austin, Goble, Leier, & Byrne, 2009) attempt to describe in depth the experience of nurses in the face of trauma and the cumulative process of nurse's suffering in the landscape of continuous exposure to human tragedy. Indeed, nurses often feel overwhelmed, horrified, and helpless when they encounter traumatized patients and their families. When being haunted by images of specific patient encounters, nightmares and intrusive memories persist and anxiety and psychological distress are enhanced to a point of experiencing hopelessness, frustration, and meaninglessness. Moral distress may be caused by the disturbing realization that one becomes gradually unresponsive, disregarding, callous, or indifferent to patients' needs. A sense of impotence, powerlessness, hopelessness, and even despair is related to the inability to provide the care they thought they ought to offer within the realities of the health care system. In their conclusion, (Austin et al., 2009) pointed that to fully understand compassion fatigue, researchers should conceive it as an individual experience with a systemic nature and environmental origins.

DISENGAGEMENT AS AN EMOTIONAL REACTION TO PATIENTS WITH TRAUMA

It is difficult to be present and willing to accompany those who suffer from trauma. Professionals feeling overwhelmed by traumatic stories or the view of physical trauma may distance themselves from the patient and his or her family (Gabbard, 2000). Disengagement, detachment, withdrawal, and disconnecting are some of the words describing nurses' choice to avoid exposures to human suffering or trauma that often create the strong desire to "walk out right now." Indeed, the sight of tragic suffering before the eyes of the nurse, blood-covered traumatized patients, deformed bodies, sometimes limbs missing, as well as stories of long-term victimization and abuse provoke horror and many other strong emotions difficult to bear.

Furthermore, it appears that some nurses have difficulty to process the intense feelings of frustration and powerlessness experienced when patients do not recover as desired or have no prospect for doing so (Austin et al., 2009). When stress levels exceed the individual nurse's limits, avoidance of any patient engagement may protect the professional from the intense irritation that may be triggered by any request for help (Coetzee & Klopper, 2010). Avoidance and emotional numbing may constitute mechanisms that regulate whether intrusive symptoms will be experienced. Avoidance may include avoiding patients who remind the nurse of a traumatic patient encounter, increased absenteeism, thought suppression, and so forth. (Mealer & Jones, 2013).

Furthermore, the experience of trauma brings with it feelings of anger and even moral outrage. Traumatized individuals often project their angry feelings into others and most often into authority figures (Gabbard, 2000). Psychological defenses such as splitting and projective identification may produce complex and chaotic responses from professionals. Furthermore, when directed toward the professional can result in nurses feeling demeaned and humiliated. In the study of dealing with traumatized patients by Collins and Long (2003), dealing with and containing anger shown by significant others was reported as one of the most difficult emotions to cope with.

On the contrary, when trauma is masked and hidden as a defense against being overwhelmed by it, it may remain unnoticed or unconsciously induce on the professional overly confrontational behaviors toward the patients or members of their families (Schermer, 2004). Therefore, strong and unexpected emotional reactions in the professional may be a clue to the presence of masked trauma. Discrepancies between assessment of patients' needs and what the professionals feel or being taken over by feelings that do not belong to them when approaching the patient may indicate masked trauma and provide useful information for patient assessment (Gabbard, 2000). On the contrary, disengagement or becoming overly confrontational with patients or their families adds to their sense of shame, failure, and hopelessness that is hidden in the masked trauma (Schermer, 2004).

In addition, when trauma is unmasked, feelings of shame and guilt are evoked, which may enhance the risk for suicide. As a result of all these complex and often chaotic reactions, professionals at risk for secondary traumatic stress or compassion fatigue may become cynical, distrustful, and suspicious, and develop diminished esteem for other people or the human race.

OVERINVOLVEMENT AS AN EMOTIONAL RESPONSE TO PATIENTS WITH TRAUMA

Traumatized patients and their families feel helpless and nurses may perceive them as such. In the study by Maytum et al. (2004) on compassion fatigue, the most frequently cited personal trigger was becoming overly involved or crossing professional boundaries. Similarly, Meadors and Lamson (2008) stress that secondary traumatization may be related to overidentification with the patient's experience or the patient's coping response, which in turn results in the professional experiencing similar levels of traumatization to that of the patient. Interestingly, Abendroth and Flannery (2006) found that nurses with a high risk for compassion fatigue exhibited "self-sacrificing behaviors" and appeared to care more for their patients than for themselves. In a similar line, Sabo (2011) stresses the need for research on the savior syndrome that appears to describe nurses' attempts to rescue the patient or the members of his or her family in the face of tragic suffering.

Gabbard (2000), in discussing the rescuer–victim paradigm suggests that when a patient has a history of victimization, the professional may feel a powerful urge to somehow repair the damage by becoming the good parent that the patient never had. Furthermore, professionals encountering traumatized individuals and their families often have the tendency to adopt the inappropriate role of victim, abuser, idealized omnipotent rescuer, or uninvolved mother (Gabbard, 2000). Similarly, Schermer (2004) notes that the professional should be alert to tendencies to be pulled into victim, perpetrator, or bystander roles. Splitting and projective identification are central in such triangles, for example, the patient may idealize a professional while providing monstrous reports of "bad" parents or other indifferent service providers, or the professional may identify with the patient against "bad" parents or indifferent colleagues (Gabbard, 2000). Professionals, especially during the first years of their career, may identify with the victim (i.e., patient) against "bad" others (i.e., perpetrator, parents, or other colleagues) who may represent members of the professional's personal history and in turn bring to surface his

or her own personal traumatic experiences. Nonetheless, a nurse's overinvolvement with a particular patient while becoming secretive and not sharing information with colleagues or believing the that he or she is the only one who can give proper and appropriate care to the patient may destroy the team approach to nursing (Morse, 1991). Furthermore, it may explain partly—at least for some nurses—why PTSD is predictive of bullying in the nursing culture (Spence Laschinger & Nosko, 2015).

MORAL COURAGE AND SELF-AWARENESS

Barnard (1995) discusses how intimacy in the face of loss and suffering may provoke the fear of being lost in the patient's pain and anguish and being overwhelmed by it. Instead of repressing or defending against the intense emotions, anxiety, and challenging thoughts stemming from tragic suffering, nurses may allow themselves to recognize, accept, and experience their grief during patient encounters as an opportunity for personal and professional growth (Papadatou, 2000). According to Lanara (1991), serving the suffering patient as a person in a cure-orientated health care system requires heroism, passion, for social justice, and zeal for righteousness. She analyzed Jesus' parable of the good Samaritan as a description of caring for the suffering patient with trauma, which is a "first aid" incidence at a road side (in Luke 10:30-35). The Samaritan (foreigner) bound up the wounds of a battered, blood-spattered helpless victim of cruel robbers pouring in oil and wine (i.e., a common remedy of ancient times). He carried the suffering individual to an inn despite loss of time, fear of robbers, becoming dirty, and other types of sacrifice required to help, in sharp contrast to Levitt (i.e., priest), who passed by indifferently although his mission was to serve compassionately those in need. Lanara (1991) concludes that serving those in need in a complex society is a difficult intellectual and spiritual achievement emphasizing the decision-making processes, "intelligent love", and sacrifice (i.e., personal time, energy) implicated in daily nursing care (pp. 154–155). Standing by the suffering patient and facing pain and human misery requires moral courage in dealing with internal and external barriers to care and persistence in building resilience to emotional situations.

Furthermore, the individual nurses bring to work their own varied histories, experiences, and emotions from their life outside the unit. Oftentimes, professionals' emotional reactions can be partly a result of their own personal history when exposed to the stress and the tensions present in their interaction to traumatized individuals and their families (SAMHSA, 2014). Therefore, self-awareness, acknowledgment of personal loss history, and unresolved issues as well as acceptance of personal limitations constitute necessary equipment in a genuine encounter in the moral space of suffering. It appears that encountering the patient as a "wounded healer" (Mealer & Jones, 2013) who has the courage to be himself or herself entails answering questions in oneself related to the meaning of suffering, a process enhancing maturity, knowledge, and wisdom. In other words, nurses are required to work through moral existential and personal dilemmas around fear of suffering and death to find meaning in work. Spirituality (Timmins & McSherry, 2012) could be a precious compass in the long-term journey of resolving feelings of grief and loss at work and of building a strong professional identity.

THE EMOTIONAL RESPONSE TO TRAUMA AS A SOCIAL PROCESS

The classical work on the social system influence on nurses' work practice by Menzies Lyth (1961) described how unconscious methods of managing emotion work can become embedded in organizational structures and how nurses focus on technical expertise and task-orientated nursing as a defense against anxiety. It appears that confidence on technical skills may help nurses to manage feelings of fear in the face of patient's life tragedies and to maintain a sense of accomplishment that counterbalances feelings of powerlessness (Cottingham, 2015). Furthermore, professional beliefs may influence the way traumatic events are perceived. The stereotype of a helper who downplays the impact of traumatic events on himself or herself because he or she feels that he or she should be capable of coping with all demands at work may contribute to an illusion of invulnerability. Cricco-Lizza (2014) identified "being a super nurse" as a coping strategy that helped nurses to gain control over adversity but which was "a source of consternation" when the patient died "despite their heroic efforts" (p. 622). Participants' reports in his study indicated "talking with the sisterhood of nurses" as a source of support for their distressing feelings but at the same time reflected "a common avoidance of speaking directly about emotive topics" (p. 624).

According to Papadatou (2000), each unit has its own unique explicit and implicit set of rules about how team members are expected to cope with difficulties and emotions at work and thus prescribe, at least to some extent, one's professional role and behavior, that is, the type of contact a professional has with a patient as well as the degree of emotional engagement in their relationship. In addition, these normative rules that constitute an integral part of organizational life guide the expression and processing of emotions. In other words, a unit's work style—blended with the individual nurse's personal loss history and philosophy of life—reinforces either experiencing or avoiding/repressing grief present when witnessing patient's life tragedies. (Papadatou, 2000). Colleagues support the individual nurse in processing emotions and may enhance his or her capacity for empathy and ability to enter into a therapeutic relationship.

IMPLICATIONS FOR PRACTICE

Acknowledgment of the unit's working style influence on emotion work delineates the plight of nursing management and other hierarchical structures to cultivate a compassionate organizational culture (Chu, 2016) and care philosophy in "moral communities" (Austin, 2012), which alleviate professionals' suffering and enable nurses to feel understood and recognized. A trauma awareness organizational culture could be supported by individual and collective development through the provision of ongoing professional training on dynamics of trauma and self-care, recognition of the nurse's individual contribution to teamwork, and the promotion of solidarity among team members (SAMHSA, 2014). Finally, the popular but controversial crisis intervention technique of debriefing as well as clinical supervision constitutes proposed approaches to cultivate trauma awareness (SAMHSA, 2014).

Psychological debriefing (Critical Incident Stress Debriefing) is an approach that was developed to help emergency service workers to process the thoughts and emotions arising from being exposed to trauma in their routine work (Hawker, Durkin, & Hawker, 2011). However, the NICE guidelines (NICE, 2005) for the treatment of PTSD advised against the provision of single-session interventions after exposure to a traumatic event on the basis of reviews of randomized controlled trials that identified harmful effects. Nonetheless, Hawker et al. (2011) described several methodological limitations of the reviewed research on debriefing and noted that "self-sacrificial professionals (whom some refer to as heroes and heroines) are now being denied a valued form of support" (p. 461). They suggest that group debriefing may be beneficial for groups of employees who have been prepared to work together in stressful situations.

By contrast, clinical supervision is provided regularly on a long-term basis and, therefore, provides a holding environment for personal disclosures that helps professionals to step back and reflect on their communication with patients and their families (SAMHSA, 2014). This may help them to gain a deeper understanding of the patient–nurse–family interactions in the face of trauma as well as to reframe their role as nurses acknowledging the limitations—and moral courage—implicated in caring within social structures that give precedence to corporate and commercial values (Austin, 2012).

CONCLUSION

Lack of understanding of the dynamics of trauma may limit nurses' ability to interact in a meaningful and safe way with patients and their families whereas internalizing and absorbing of unmanageable emotions may lead to secondary traumatization. A compassionate organizational culture, clinical supervision, and ongoing education may protect health care professionals from secondary traumatic reactions and also help them to gain a deeper understanding of their communication and interactions. In the context of adequate organizational mechanisms for individual and team development, caring for the wounded may be not only a source of suffering, anguish, and stress but also an arena of personal maturity and self-actualization. Otherwise, the emotional demands entailed in caring for the traumatized may exceed caregivers' ability to handle them and result in the failure of professionals, health care organizations, and societies to share part of the patient's suffering and pour "oil and wine" in the wounds of those in need.

KEY POINTS

- Exposure to trauma evokes intense and sometimes overwhelming emotions in nurses. Difficulty to process their emotions may lead to disengagement or overinvolvement and adoption of maladaptive roles. Strong and unexpected emotional reactions in the nurse may be a clue to the presence of masked trauma.
- The narrative or the sight of tragic suffering may elicit in nurses a powerful urge to somehow repair the damage or bring to surface their own personal traumatic experiences. Becoming overly involved or crossing professional boundaries frustrates, deflects, and diverts the nurse from empathically caring for the patient.
- There is a need to cultivate a trauma awareness organizational culture that acknowledges the individual nurse's suffering and contribution in teamwork. Ongoing professional training on trauma dynamics, self-care, and clinical supervision may deepen nurse's understanding of the impact of trauma on his or her work culture.

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