SECONDARY TRAUMATIZATION OF WORK-RELATED REHABILITATION CLIENTS

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Many health professionals hold the belief that individuals involved in personal injury suits/Workers' Compensation claims exaggerate their pain and disability due to the potential for secondary gain, e.g., social attention, work avoidance, or financial compensation. This phenomena has been termed "compensation neurosis", although a review of the literature shows little justification for the term's continued use (Solomon 1988). This article outlines the worker's response to the impact of such widely held beliefs. Some of the doubts about claimants stem, in part, from an influential paper in the early 1960's by Dr. H. Miller, a British neurologist, who argued that accident claimants deliberately exaggerate or deceive in order to substantiate their claims. As evidence, he cited that fact that once their claims are settled 90% of these people returned to their former or similar jobs. Follow up studies, however, have failed to replicate these findings (Kelly, 1975; Oddy et al, 1978; Tarsh & Royston, 1985). It is no longer justifiable then, for people in the field to claim that it is well known that patients with such symptoms immediately return to work after their claim has been settled. Nonetheless, and notwithstanding these studies, the majority of claimants attending my office for neuropsychological and/or psychotherapeutic services report all too often disconcerting or critical comments, delays in the medical and psychological assessments, repetitious evaluations, delays in reaching settlements, symptom minimization or denial, and perceived lack of empathy for their conditions. The following comments relate to rehabilitation patients attending for clinical psychological services on referral from a wide variety of vocational rehabilitation agencies and personnel. The comments to follow do not, and should not be interpreted to, reflect any one particular agency or person or persons.

My practice involves the assessment and treatment of sexual victims (as well as offenders) and a wide array of rehabilitation clients including those who have suffered brain and other physical injuries, and/or psychological distress producing, amongst a number of effects, depression, post traumatic stress disorder, and adjustment disorders.

Early in 1995 one of my clients who had sustained a horrific mill accident with brain and multiple other injuries was perusing my office library when he came across a book entitled "**I Can't Get Over It: A Handbook for Trauma Survivors**" by **Aphrodite Matsakis, Ph.D., a specialist in post-traumatic stress disorder**. The book is designed primarily for victims of crime, rape, sexual abuse, family violence, natural catastrophes, and vehicular accidents; not suffering from these particular traumas, my client readily

identified with the symptoms outlined in Chapter 4's "The Three Levels of Victimization". This insight not only led to fruitful discussions thereafter but to a better appreciation of the impact the rehabilitation system, has, at times, on the clients it serves. With Dr. Matsakis' approval I am using her secondary victimization as a template for discussing the effects of Pre-traumatization by the rehabilitation system on its clients.

THE TRAUMATIC EVENT

Matsakis defines victimization as occurring on three levels: the traumatic event itself (e.g. **the work-related injury**), **secondary wounding** experiences, and acceptance of the victim label. In Level I the victim has their basic assumptions about themselves, human nature, and the nature of the world shattered. In keeping with post traumatic stress or adjustment disorders the trauma may produce significant psychological distress including confusion, depression, anxiety, distrust and the like. The worker's assumption about personal invulnerability is shattered, as well as the notion that the world is orderly and meaningful, or that the worker is basically good and strong. The loss of invulnerability may, in turn, produce a loss of sense of safety, together with the fear of further injury or other harm. Those familiar with Post Traumatic Stress Disorder will recognize that these feelings of vulnerability may well develop into a sense of doom or a foreshortened sense of future. Social withdrawal, impaired frustration tolerance and unwelcome dependency feelings are also common outcomes with injured workers.

Being traumatized in the workplace often leads to loss of self image, memory impairment, and concomitant feelings of helplessness and powerlessness. Many, by virtue of their injury, are forced into dependency roles with a host of rehabilitation personnel, physicians, psychologists, adjudicators, adjusters, and job placement officers. For the vast majority of rehabilitation clients this represents a marked shift from their previous sense of being able to "take care of business" in independent fashion. Many claimants find it very difficult to accept their "neediness" as normal to their circumstances.

The trauma-produced regression to dependency leads many, though not all, claimants to want to be cared for and to have assurances. Consider how difficult it is, then, to hear rehabilitation personnel question their integrity, or otherwise portray or present an uncaring response to their needs. The reaction of the caregiver is, then, particularly troubling when the claimant does not want to be in the "one down" or "child" position in the first place. Some claimants by-pass the human caregiver altogether and turn to alcohol or other potentially addictive substances; one's ability to self-medicate is predictable, less
frightening and less humiliating than turning to other people for help, particularly so if the caregiver is perceived to be unsympathetic.

Social isolation is common with PTSD or adjustment disorders. With the work-related claimant the isolation may reflect the initial period of physical recuperation, changes in physical appearance or presentation, a change of self-image, embarrassment over not working, and general loss of self-esteem. This dynamic runs counter to the aforementioned dependency dynamic.

One's rage and anger can be turned against oneself or against others who either contributed to the injury or to those agencies which have failed to mete out "justice" when one has been carelessly harmed. Claimants like to think that when they have sustained a significant trauma "justice" will be done and that those who brought about their trauma, if identifiable, will be disciplined. In many cases, those employers or fellow employees who are morally culpable seem to slip through the net and, for all the claimant knows, continue to work without punishment or fear of same. This, needless to say, can be a source of significant frustration and anger to the worker, compounded by the worker's difficulty in securing documents relevant to their injury, and the prohibition against taking legal action (in many jurisdictions).

More salient, in my view, is the "secondary wounding" defined by Dr. Matsakis (p. 80). She defines secondary wounding as emotional injury inflicted by anyone from strangers to family and friends or helping professionals who, through callousness or ignorance, do more harm than good. Instead of providing a sense of support the aforementioned individuals or caregivers contribute to a sense of shame for having been traumatized in the first place, or for even asking for help. Matsakis cites several poignant examples which mirror comments my clients have made, i.e., "You weren't hurt enough to be entitled to benefits" or "It happened weeks (or months or years) ago. You should be over it by now". The effect of this minimizing may create additional reporting of trauma, and provide an invitation to the worker to report a higher frequency/severity of symptoms than otherwise might exist to receive "validation".

SECONDARY WOUNDING AND EXPERIENCES

Secondary wounding is considered to occur when the institutions or caregivers, to whom the worker turns for assistance, respond with disbelief, denial, discounting, blame, stigmatization, and denial or delay of assistance. In the case of the work-related trauma survivor, the caregiver or others may deny or disbelieve the extent of the person's trauma or its meaning to the worker and its impact on their life or that of his family. For example, a client of mine has, amongst a host of other injury-related difficulties, been unable to kiss his wife. The caregivers he spoke with regarded this as of no great significance, as it was unrelated to his employability-yet it has significant meaning for him on a marital-sexual

level.

Stigmatization is said to occur when others, either inside or out of the system, are critical of the worker for normal reactions to the trauma. This can take different forms including misinterpretation of the worker's distress as a sign of pre-existing psychological problems or moral or mental deficiency. In other cases one or more caregivers may imply or make an outright statement that the worker's symptoms reflect a desire for financial gain, attention, unwarranted sympathy, or work avoidance.
In other cases workers are arbitrarily deprived of much needed services or they have to make repeated submissions and multiple applications for the services, or the services have been provided but the costs for the services, having been paid by the worker, are either delayed in their reimbursement or refused altogether. For some workers the secondary wounding experiences are described as more painful and devastating than the original trauma.

Further in Chapter 4 of her book Dr. Matsakis identifies six specific types of secondary wounding responses: denial and disbelief, discounting, blaming the victim, ignorance, generalization, and cruelty. These wounding responses are well identified in the sexual abuse survivor literature but, to my knowledge, inadequately identified in the rehabilitation literature, if at all. Empathic caregivers will help their clients identify these six types of secondary wounding responses, and help the worker recapture their sense of self which includes health on the one hand and identification of the sources of oppression in the system on the other.

The worker may also be assisted in acquiring or exercising assertiveness vis a vis refusing to accept (if that is the worker's position) the "common wisdom" of the agency, medical or psychological staff about their condition and vis a vis insisting on being heard as to what is happening in the worker's medical, emotional, familial, and vocational or academic experience-in other words, to allow the worker to see him/herself in a collaborative role as an expert about their condition, along with other experts, who have training and experience in a particular field but who do not and cannot claim to have the day to day experience of the injured worker.

In cases of sexual assault it is typically the offender, or an insensitive family member, police officer, or mental health provider (fortunately these types of occurrences are less frequent with increasing education regarding victim psychology) who engages in secondary wounding. Within the vocational rehabilitation realm, denial and disbelief more commonly come from rehabilitation, medical, and/or psychological personnel. Some such personnel express denial or disbelief, not that the worker had a trauma (which is difficult to deny given the abundance of records), but the worker's phenomenology, or their statements as to what is occurring in terms of their

current physical/psychological status or ability to return to work. Workers who are already in a dependent state, find such disbelief or discounting troubling, and worry, at times, that perhaps they are "weak" or are exaggerating their circumstances. Sometimes they abandon their own experiences (the end result of invalidation) and attempt to adopt the viewpoint of the caregiver. This cognitive shift, while productive for the minority of malingerers, is counterproductive in the general case. In one recent case a fire-fighter, whose parents were alcoholic, was traumatized when an elderly alcoholic male was burned to death in a house fire. After the fire the other firefighters commented that "no loss..he was just another alcoholic". This trauma not only reactivated issues related to his growing up in an alcoholic home but also the insensitivity at the loss of human life, even if alcoholic human life. He was told by rehabilitation staff, however, that he was not definitely not traumatized and should return to work, even though be satisfied criteria for post-traumatic stress disorder.

Blaming the victim is the third of the secondary wounding responses. Such woundings that I am familiar with include statements that the worker should not have taken the job in the first place or should have quit when he saw that his place of work was dangerous. Ignorance is yet another type of secondary wounding response. In one case an electrocution survivor was advised by a rehabilitation consultant to consider taking a job working on high power lines. Needless to say, the worker was incredulous that such a recommendation might be made. Generalization is yet another wounding response which seems endemic to the rehabilitation system. I have had many workers state that they feel dehumanized by the label of "rehabilitation claimant". It seemed that no matter what they did or said their conduct was considered only in that light - the label comes to define the worker, not the worker's own history and hopes for the future.

The above-described wounding responses are highly troubling to the workers I have spoken with. One of the difficulties, of course, is that the worker cannot determine whether the wounding response arises from a desire on the part of the caregiver to cause psychic pain, or ignorance, generalization, or some other distancing mechanism on the part of the caregiver. Matsakis conjectures that this type of psychological revictimization can reflect difficulties with intimacy, or a general numbing found throughout society making it difficult for people to empathize with each other's pain, even within their own families.

ACCEPTANCE OF THE VICTIM LABEL

The third of the three levels of victimization involves victim thinking. Again, victim thinking is well identified in the sexual abuse literature but is unexplored in the rehabilitation literature. Victim thinking may include chronic and persistent thoughts of helplessness, betrayal, guilt, self

blame, and self-stigmatization. More specific examples might include the following: "I shouldn't expect too much good to happen from here on in", "I can do nothing to make my life better", "No one will hire me as an injured worker", "I am always going to feel this way", "I am going to have to be extra competent in order to compensate for my shortcomings", "I am afraid to try something new in case I make a mistake", "When people look at me they will know that I am different", "It would have been better off had I died during the accident", "People are either for me or against me", and "I am never going to get over what happened to me". This, needless to say, is not an exhaustive list but serves to illustrate the kind of thinking that injured workers may experience.

While victim thinking may represent an adaptive response initializing to secondary wounding experiences, in the long run, victim thinking may make it difficult to experience full vocational rehabilitation. If the worker exhibits victim thinking he/she needs to be reminded that the original trauma and/or the secondary wounding experiences may have initially created a need for defensive, victim thinking. At the same time, the worker needs to be reminded that victim mentality, while possibly serving short term interests, does not serve long term rehabilitative interests, and doesn't fit the current situation at present. To position themselves on a positive rehabilitative track, injured workers need to assertively confront those who engage in secondary wounding, and make their own cognitive shifts, i.e. abandon perfectionistic thinking (both with respect to themselves and to their caregivers), accept that they are having personal difficulties, avoid "all or nothing" thinking, and terminate maladaptive survival tactics (i.e. passive-dependency, withdrawal, inappropriate anger, etc.). Cognitive-behavioural strategies may be beneficial in this regard. What is important is that the worker be validated, and helped to reclaim his/her view of self as one with not only a past, but a future in some meaningful role.

In sum, secondary wounding, rather than spurring the claimant, on to a rehabilitative "fast tract", engenders cynicism, doubt, betrayal, and distrust of the "system". Moreover, just as some caregivers generalize their experience with a small minority of malingerers to the whole claimant population, worker-claimants themselves may generalize their doubts about the system to all who participate in it. This dynamic predictably delays the rehabilitative process and, from my experience, leads to additional and unnecessary evaluations and re-evaluations and nauseam until the worker literally gives up in despair and fantasizes exiting the system by going on financial assistance or in extreme situations, via suicide. (Parenthetically, I would estimate that 50% of my rehabilitation clients have actively contemplated suicide at one time or another, not as a reflection of the initial trauma but as an outcome of secondary wounding). In other cases the worker may turn his/her despair and anger outward against

the agency in an anti-social fashion, e.g., by damaging rehabilitation agency offices, threatening caregivers, and the like. All of these events are a matter of record in the province of British Columbia and, I have little doubt, exist in other provinces and states as well.

The path out of this psychological cul de sac, in my view, would include, but not be limited to, a clear expression of caregiver empathy and compassion (not cynical doubt) for the worker, minimizing the number of medical and psychological evaluations needed to determine the worker's vocational status, minimizing the number of personnel the worker has to deal with (i.e., having the same personnel maintain the claimant's file from start to finish; nothing is more discouraging than meeting with 5 or 6 different rehabilitation coordinators or disability claims adjudicators in the course of one's rehabilitation process), familiarity with the worker's file (not to be familiar with the file prior to contact with the worker leads to the conclusion that the caregiver is disinterested in the worker), and the simple courtesy of responding to correspondence and telephone calls. I have encountered many workers who express frustration over not hearing from caregivers and rehabilitation personnel in spite of repeated phone calls and correspondence. I suspect that this goes to the issue of caseload numbers and burn out, or possibly a reflection of the relative value placed on collaborative recovery versus worker blame.

Overcoming the secondary wounding inflicted by ill-informed or burnt out caregivers requires the worker to identify the secondary wounding experience and to distance him/herself from the negative responses on both the emotional and the mental level. This means learning not to react to the secondary wounding as "catastrophic" or devastating, but directing the blame where it needs to go, i.e., on the secondary wounder.
This type of distancing, in many cases, will require empathic support from family and/or professional caregivers who are in a position to counter the insensitivity expressed by those caregivers who may be hurried poorly trained, or simply burnt out. A professional caregiver, in particular, may be helpful in identifying the negative self-talk which may be generated by thoughtless comments on the part of retraumatizing caregivers.
It is always important to maintain a keen sense of one's own worth, regardless of one's physical or psychological disabilities, and regardless of blaming or negative comments made by others. By affirming one's own worth as a person one is helped to feel, at least to a certain degree, more in control of one's future and more objective, and to regain a sense of self-efficacy and personal competency.

Workers, of course, can make their own contribution to facilitating the rehabilitative process. With the help of rehabilitation personnel and/or mental health professionals they can be invited to challenge their victim thinking and to acquire personally meaningful ways of articulating their

frustration with the "system". This will include enhancement of self esteem, assertiveness training, depression and anger management, and resolution of the initial trauma via psychotherapy.

Claimants can also facilitate the process by being prepared for their meetings, having relevant documents, having their questions written down and rehearsed (particularly in the case of memory impaired workers) and learning to exercise a modicum of patience and tolerance for their caregivers who are, in many cases, over-worked, generally unappreciated, and understaffed.

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