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“Some Things Stick”: Secondary Traumatization Among Police Officers and Medical Personnel Meeting With Raped Women

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Professionals who work with traumatized individuals can develop secondary traumatization (ST). Little research has focused on ST among police officers and medical personnel who meet with raped women. Based on focus groups with these professionals ($N = 28$), a deductive thematic analysis was conducted with a focus on ST. Participants described listening to stories with traumatic content, and they showed signs of cognitive and emotional changes. They also described a lack of support, forcing them to find both constructive and destructive ways of coping on their own. Negative effects may lead professionals to continue working without understanding how they are affected. This can hinder professionals from taking care of themselves as well as from offering proper treatment to the victims they meet.

Keywords: medical personnel, police, raped women, secondary traumatization


Sexual abuse and rape cause physical and psychological suffering in victims, who report feelings of guilt, self-blame, loneliness, and shame as well as sexual difficulties, flashbacks of the abuse, and/or symptoms of posttraumatic stress disorder (PTSD; Wilson & Miller, 2016; Wilson & Scarpa, 2017). Positive reactions such as comfort, emotional support, and empathy to disclosures of abuse have been associated with improved psychological health among victims (Campbell, 2005; Greeson et al., 2014), whereas negative reactions, such as victim-blaming and disbelief, can have a harmful effect (Ahrens et al., 2010) and make victims reluctant to seek help again (Campbell, 2005). It is not surprising, therefore, that most sexual offenses are not reported to public authorities (Brå [Brottsförebyggande Rådet] [The Swedish National Council for Crime], 2019), and meeting with women who have been raped is demanding on responding professionals.

Meeting with victims and listening to their stories is often associated with emotional distress, discomfort, and uncertainty in professionals (Rudolfsson & Tidefors, 2013). These effects may have impacts not only on professionals themselves but also on their ability to engage empathically with victims (Bride et al., 2007). Professionals have said that meeting with and listening to the stories of victims of sexual abuse is difficult (Rudolfsson, 2015), partly because acknowledging the reality of sexual abuse can be upsetting and partly because such accounts may touch on elements of sexuality that evoke professionals' own sexual experiences and fantasies (Tidefors & Drougge, 2006). This association may induce professionals to identify more deeply with the traumatic stories, making the encounter particularly complex to process (Pearlman & Saakvitne, 1995).

Police officers (POs) and medical personnel (MP), working at emergency units, are often the first to meet the traumatized individual in the acute situation and are at high risk of experiencing potentially traumatic events across their careers (Kerswell et al., 2020).

Secondary Traumatization

Numerous attempts have been made to explain the negative effects on professionals who interact with people who have been traumatized (Salston & Figley, 2003). Figley (1995) defined *secondary traumatic stress* (STS) as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other” (p. 7) and the “stress resulting from helping or wanting to help a traumatized or suffering person” (p. 10). Figley and coauthors also described *compassion fatigue* as the consequence of an empathetic response to traumatized individuals (Adams et al., 2006; Figley, 1995). The term *burnout* overlaps with both compassion fatigue and STS, in that they all describe emotional exhaustion (Maytum et al., 2004), although burnout does not necessarily entail exposure to victims of trauma (Osofsky et al., 2008).

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McCann and Pearlman (1990) used a constructionist self-development theory to explore the psychological effects of traumatic material on therapists who engage with victims of sexual abuse. They identified changes in worldview, cognitive schemas (beliefs, assumptions, and expectations about oneself, others, and the world), and belief systems—changes that were stable over time. These changes were later defined as vicarious traumatization (Cohen & Collens, 2013). Although details distinguish various definitions of the effects on professionals of interacting with traumatized people, many similarities have led some researchers to use the terms interchangeably. Following many other researchers (Greinacher et al., 2019), we use ST in this article as a generic term for the phenomena described earlier.

In summary, ST can be seen as a natural consequence of the behaviors and emotions evoked by the stress of knowing about another's traumatic event, helping or wanting to help that person (Figley, 1995), working with traumatized individuals, and responding with empathy (Adams et al., 2006). Similarly, as victims experience a loss of control and sense of security, professionals who listen to stories with traumatic content can alter their perception about safety and control (Pearlman & Saakvitne, 1995). Thus, professionals who are in contact with traumatized individuals can develop a traumatic response without having experienced the traumatic event themselves (Baird & Kracen, 2006), with symptoms almost identical to those associated with PTSD (Baird & Jenkins, 2003). However, the development of symptoms of ST differs from PTSD, in that the professional experiences the trauma indirectly by listening to stories with traumatic content (Figley, 1995).

First Responders Meeting With Traumatized Individuals

Previous research has mainly focused on the prolonged exposure to traumatic material, among professionals with long-term contact with traumatized individuals, such as therapists or social workers (Zeidner et al., 2013). Few studies have focused on first responders, such as POs and MP, who meet with traumatized individuals in acute situations. Although some individuals do not report prolonged negative effects on mental health, previous research has found that first responders are at prominent risk of developing PTSD, depression, anxiety, and substance-related disorders throughout their careers (Thornton & Herndon, 2016).

Research shows that the risk of ST can be reduced when professionals have access to professional support (Bégar & Severinsson, 2006). The combination of being able to discuss the stories with colleagues, attending training workshops, limiting workloads, spending time with family or friends, and having supervision is considered most helpful (Pearlman, 1999). Some studies show that MP are more resilient than POs. One suggested explanation is that more precautions are taken to create support systems and interventions for health-care workers in their work environments (Osofsky et al., 2008). There is also a general understanding of the macho culture within policing to cause POs to try to handle their emotions on their own (Rich & Seffrin, 2012).

Variability in professionals' psychological health following a traumatic event has also been linked to different psychosocial and demographic variables (Kerswell et al., 2020). Personal history of trauma, social support, coping strategies, gender, and length of

service are variables that can affect the outcome (Ménard et al., 2016). For example, some studies found gender-based differences, with female POs showing a higher risk of developing PTSD and depression (Beck, 2011), whereas others found no gender differences in PTSD rates among POs (Pole et al., 2001). Studies among MP have also recognized that women are at higher risk for PTSD (Carmassi et al., 2018). It is possible that female professionals are exposed to more meetings with raped women, as assignments to conduct rape interviews are based on the professionals' gender in several countries (Hodgson & Kelley, 2002), however, not in Sweden. Victims of rape have also reported that they prefer meeting with a female professional and that they feel more comfortable discussing the intimate details of a sexual assault with another woman (Temkin & Krahé, 2008). It might be that female professionals are better equipped to understand women victims, as there is a higher degree of identification (Martin, 2005). Empathy (cognitive and emotional understanding of another's experience resulting in an emotional response reflective of a view that others are worthy of compassion and respect; Barnett & Mann, 2013) and identification with the victim have been described as essential resources in meetings with victims of sexual abuse (Bride et al., 2007). However, empathy and identification may also increase the risk of ST, as it contributes to professionals' sharing the victims' feelings and symptoms (Turgoose et al., 2017).

Although previous research has shown that both POs and MP are at risk of developing symptoms of trauma, little is known about *how* these professionals get affected when meeting with women who have been raped. Previous research also highlights the need for more qualitative studies that address the concerns raised regarding ST of POs and MP meeting victims of rape (Turgoose et al., 2017).

Aim

The aim of this study was to gain a deeper understanding of the psychological effects and potential difficulties POs and MP experience in their meetings with women who have been raped. The study also aimed to explore how POs and MP talk about managing these difficulties and their need for support in such processes.

Method

Focus groups offer the possibility of novel findings, which makes them suitable for exploratory research (Yardley, 2000). Participants in focus groups, unlike those interviewed alone, can disagree, contradict, and support each other's statements (Millward, 2006). Although focus groups often comprise six to eight participants per group (Rabiee, 2004), this study was based on seven focus groups of two to six participants each, complemented by one individual interview.

Participants

A total of 28 professionals (16 POs: 11 women and five men; 11 first responders and five investigators; age: mid-20s to late 50s; work experience: 2 to ~30 years) and 12 MP (all women; four assistant nurses, four nurses, and four medical doctors; age: mid-20s to early 50s; work experience: 2 to ~10 years).

Procedure

This study is part of a larger research project titled *Female Rape Victims: Quality of Initial Police and Medical Care Contact*, funded by the Swedish Crime Victim Compensation and Support Authority (grant no: 3108/18). Following this study focused on POs and MP, forthcoming studies will focus on the experiences of women who have filed a police report and/or sought medical care after rape. The studies have been ethically reviewed and approved by the regional ethical board in Gothenburg and the Swedish Ethical Review Authority (ref. no. 883-18/2020–06910).

Lisa Rudolffson recruited POs through the Swedish Police Authority, who forwarded a letter of inquiry in different police districts in Sweden. The inquiry described the aims of the overall project and the focus group study and promised that participation was voluntary and anonymous. Professionals who were interested in participating were urged to contact Lisa Rudolffson, who then gathered participants at a time that suited them all. Two focus groups were conducted at the University of Gothenburg, another took place at the police department where the participants worked, and an individual interview was conducted at the police department with the one participant working there who was willing to participate.

Lisa Rudolffson recruited MP in a similar manner: Gatekeepers forwarded the letter of inquiry to personnel in different gynecological emergency health-care units in Sweden. Interested participants were urged to contact Lisa Rudolffson, who gathered participants at a time that suited them all. Two focus groups were conducted at the University of Gothenburg and two at the hospitals where the participants worked. Two groups consisted only of nurses and assistant nurses, and two focus groups only of medical doctors.

The focus groups and the interview each lasted 1.5 to 2 hr. All focus groups and the interview were moderated, audio-recorded, and transcribed verbatim, including pauses and nonverbal communication, by Lisa Rudolffson.

Question Guide

The question guide first asked the participants to share a memory of meeting with a woman who had been raped. The following questions asked how often they had met professionally with women who had been raped; what feelings these meetings evoked; what, if anything, they found difficult in these meetings; and what professional practices they perceived to be helpful for the woman. All questions were open ended, and the moderator followed the concerns of the participants throughout the discussion. Follow-up questions were adapted and posed so that the participants could give concrete examples and develop their reflections. All focus groups ended by asking how they felt about discussing this topic in a focus group and how they thought they would feel afterward. Participants were urged to contact Lisa Rudolffson if they thought of something new or if they needed to discuss the feelings evoked by participating in the focus group.

Analysis

The material was analyzed using deductive thematic analysis. This method enables themes to be identified and constructed using theory and a top-down approach focusing participants' experiences

(Braun & Clarke, 2006). In this study, we identified themes using Figley's theories (1995) of ST, that is, professionals' empathic responses combined with their development of secondary traumatic responses (e.g., PTSD), emotional and cognitive changes, and fatigue. While focusing on such changes, we also tried to stay close to the participants' discussions.

The material was analyzed by hand using no software. In the first step, Enkela Sinani first read and reread the transcripts in their entirety and in the second step scrutinized each transcript, line by line, paying equal attention to the entire dataset to ensure complete consideration of repeated patterns in the data. Both authors noted and discussed the data, and Enkela Sinani labeled all relevant material with codes. The 95 codes reflected features of the data related to ST (that is, parts that related to participants' emotional and/or cognitive responses, ways of managing these, and needs for support). In the third step, authors reviewed and discussed the codes of each transcript. Codes with similar content were grouped in 27 preliminary subthemes. In the fourth step, themes with insufficient supporting data (i.e., few quotes) were incorporated into a higher level of consolidated themes. Initial subthemes were then organized under eight general themes (e.g., powerlessness, changes in conception of the world). In the fifth step, the eight general themes were organized under two main themes: risks for ST and consequences of ST. Both authors then reviewed the themes to ensure that all relevant initial codes were represented in the thematic structure. In the sixth step, authors renamed the main themes as (a) emotional responses and (b) cognitive changes. Finally, the data extracts were reviewed to find quotes that best captured the essence of each main theme and subtheme.

Findings

The following text presents the main themes and subthemes that emerged in the analysis. Quotations have been lightly edited to abbreviate reading. After each quote, the participant's profession is noted as PO, assistant nurse (AN), nurse (N), or medical doctor (MD), followed by their gender. Results are summarized in Table 1.

Emotional Responses

This theme captures the emotional responses participants described in their encounters with women who have been raped. Participants talked about feeling empathy for the victim and how they identified by thinking about how it would feel if they themselves were victimized. Participants also described feeling powerless, as they often knew beforehand that the woman they met would probably not get legal justice, and they described lacking adequate emotional and structural support to cope with these emotions.

Table 1
Main Themes and Subthemes

Main theme	Subtheme
Emotional responses	Moved by empathy What if it were me? I feel powerless and abandoned
Cognitive changes	I am growing numb The world is not a safe place

Moved by Empathy

Although the participants stressed that their ability to feel empathy for the woman was prerequisite to being able to offer adequate treatment, they also described how they could sometimes become almost too empathetic. Meeting with victims sometimes overwhelmed them emotionally and led to their feeling insecure about the best ways to offer help. Participants described how feeling empathy could make it difficult to remain professional and keep appropriate personal distance. Some described not being able to shake the feelings off and carrying the women's hurt with them: "It's not just a job. You cannot shake this off. And you go home and like [sounds of crying] cause it stays with you. Although I'm not working that case anymore, I still think about it . . ." (PO, female).

The participants discussed how they could become so overwhelmed by the urge to care that the boundary between professionalism and privacy became blurred. Mainly POs talked about how their work entailed listening to stories of sexual violence in graphic detail. When victims gave details about their reactions and feelings during the abuse, POs said it was almost impossible not to get empathically involved and to believe that the stories were true. Others said that their meetings with victims became memories stored in the far backs of their minds, which even months after the actual meeting could intrude unexpectedly.

I try to put it in a box somewhere at the back of my mind. And then, well, memories can reappear in different situations, even though you may not remember the patient . . . then suddenly, after several months, it pops. (MD, female)

Participants described how different women evoked different emotions. Some found they became more empathically involved with women from socially vulnerable groups, such as those who struggle with addiction and homelessness. Such empathic responses led to existential thoughts about the difference in conditions between the women they met and themselves. Participants working as MP were more likely to talk about how meeting with women who lacked even the basic necessities stuck to them.

[T]he worst thing was taking her clothes as evidence because she didn't have other clothes. She had nothing, except for what she was wearing, so we had to give her clothes from the hospital. . . . such meetings, they really stick. (MD, female)

POs discussed how they had to make the woman go through the abuse once again during interrogation. Some described hoping the interrogations would not go on too long, as the woman often did not have the strength to go through it. If the interrogations became too long, it became a struggle for the POs to stay focused as well.

[H]ow do you make the decision to stop the interrogation? Cause you think "By God, we will have to be here for hours and hours." In some ways, you have to keep it short for her sake as well . . . Cause they often have this huge need to talk and to let it go. (PO, female)

What If It Were Me?

Mainly female participants often discussed how they could picture themselves in the victim's position. Some talked about meeting

with women who reminded them of themselves, and some even said it was just luck that they had not been raped themselves.

(1) If it can happen to them, you kind of wonder why it hasn't happened to you . . . (N, female); (2) All women can be unfortunate enough to get raped [sounds of agreement]. (N, female)

Participants also tried to understand what the victim might have been thinking and feeling during the rape, and they reflected on how they themselves would have reacted. They discussed their own view of sexuality as something consensual and beautiful. Female participants in particular related to their own sexual experiences and talked about sexuality as something intimate: "Yes! In general, it is very intimate. . . . It's supposed to be something nice and something you want" (AN, female).

The participants also described thinking about how it would feel to meet with themselves as professionals. They reflected on what kinds of previous experiences these women might have had with other professionals, or which professionals they would be most comfortable meeting. Female POs described using the word "we" to make the victim feel safe with them.

With everything that relates to violence against women, I think it works by talking about it as "we" . . . That you say, "We are not supposed to put up with this, we don't deserve this, we should be treated better." Then she feels, or at least I've perceived it that way, it makes her feel strengthened. (PO, female)

POs discussed whether they were more likely to send a female or a male officer to respond to a woman who had been raped. Both female and male participants said it was probably easier for a woman to understand the female victim's experiences. Although they stressed that there were no guidelines on this within the Police Authority, some participants reasoned that because most perpetrators are men, women victims would probably feel more comfortable meeting with another woman. "Well, it's not a rule that it's better to send a woman, but it seems like common sense" (PO, male).

I Feel Powerless and Abandoned

Participants described often feeling that they were left to deal with their emotions on their own. They described feeling powerless about the women's scarce possibilities for legal justice and worried about letting them down. POs more than MP talked about how they imagined the woman had gathered her courage and how they had to disappoint her by not being able to take her case to court. POs described feeling powerless within the legal system. They felt their work was almost in vain because they so often knew beforehand that the case would not go to trial. Some described how the woman shared their own sense of powerlessness and had a preconceived expectation of being let down. "Many come here with that perception from the get-go, like, 'This is going to lead to nowhere'. And you have to tell them 'We do the best we can' because we do try!'" (PO, female).

All participants discussed being lonely in terms of lack of support. Although some participants described having colleagues who supported them, others described a lack of emotional support from their colleagues. Participants described rarely speaking about what it meant to carry the burden of a victim's story within them. Some

also talked about lacking support outside work, where their partner did not want to listen to sad stories.

[Y]ou come home, and your partner doesn't want to talk about it because it is awful. . . . Then who are you to talk to? There's a need to talk about it, and there's a need for someone to react to it. (N, female)

POs talked about how support groups and supervision were available mainly for officers working as investigators. Officers working as first responders said it was their own personal responsibility to ask for support—something they found hard to do. POs working as both first responders and investigators said that because the supervision took place in group settings, it was difficult to express their personal experiences and feelings.

I like my colleagues, I like working with them and whatnot, but I don't interact with them privately, and supervision isn't just about our work; it's about me as an individual, my feelings, and so on . . . Am I supposed to share my inner thoughts with others? Cause that belongs to me. (PO, female)

POs described a general culture in which officers were supposed to handle their emotions on their own and not sharing what was hard with others. One PO described how he had filed a report of work-related injury and demanded rehabilitation after working a rape case. He described asking for help as taboo within the Police Authority and how his colleagues had seen him as weak for not coping.

I filed a complaint about that, and I've been going to rehab after that, and I'm going to continue doing so. And it's like, it's kind of a taboo, like, "What's wrong with him?" and "He can't take the pressure," and such. (PO, male)

POs talked about the lack of resources as an obstacle to their acting professionally. They expressed concern about the lack of basic amenities in the interrogation rooms, such as a water dispenser or a coffee machine. All described a lack of insight within the Police Authority on the importance of the room: "Our interrogation rooms are all under criticism, and they've always been like that. I mean, interrogations are our most important evidence, and they're not taken seriously by the Authority [sounds of agreement]" (PO, male).

Participants also described how an intense workload affected the quality of their work. MP described often wanting to stay with the victim but having to attend to other patients' needs. Many described how their heavy workload affected their physical and mental health. Participants also described how colleagues at their unit had left because they lacked resources necessary to offer adequate treatment of victims and at least partly, to take care of themselves. "If you apply for our department, you usually stay. Those who do not, they leave because they cannot take it, I mean, they're exhausted" (PO, female).

Cognitive Changes

Both POs and MP described how their work had changed them. They discussed a fear of growing cold and becoming numb. Some described how their approach to victims had already changed. All discussed how their meetings with raped women had contributed

to changes in their perceptions of the world, making them increasingly aware that the world is not a safe place. The changes in their perceptions of the world sometimes caused participants to go beyond their professional roles.

I Am Growing Numb

POs described how they often became so engaged with the victim during an interrogation that they felt exhausted afterward. They also described the administrative work as a burden. "[Y]ou're completely washed out afterward [sounds of agreement]. You're completely washed out because you're all focused on getting as much information as possible" (PO, female).

MP also described feeling exhausted, although not as often. Some feared they would grow cold and numb, and they described feeling unable to reflect on how meeting with raped women actually affected them.

It's a constant flow, and the time to stop to think about how all this is affecting me just isn't there. And you don't want to become numb to it; that's something that you definitely don't want to become. (N, female)

Although acknowledging their fear of losing their empathic response, many participants admitted that their approach to victims had actually changed over time already. With experience, their focus on being professional had increased, making the participants more goal-focused. "It's still a balancing act, but I've noticed a tendency toward me becoming a bit more correct, goal-focused, handling the task at hand" (PO, female).

Sometimes, the focus on professionalism seemed to make the participants overly pragmatic, viewing the woman as a crime scene rather than a person. The focus shifted to gathering evidence to catch the perpetrator and less on meeting the woman in her vulnerable state. "I see her as a crime scene because she is one. After all, a crime has been committed on her, so to say" (AN, female).

The World Is Not a Safe Place

MP more often than POs, and women more than men, described having become increasingly aware of women being at risk "It can happen to any of us [women] any day, cause we really are not safe anywhere" (N, female). They also described becoming more wary of men in general, viewing most men as potential rapists. Some also described having felt hatred toward most men because of the hurt they caused their patients.

The first times while I was working here, it was just like I went into a total darkness, and I actually hated all men. I saw every man as a potential rapist and just became this complete man-hater [sound of agreement]. (N, female)

One participant, working as a nurse, talked about how her increasing suspicion toward men had even made her think about changing her sexual orientation; she imagined she would feel safer in sexual encounters with women. Many found it hard to accept that some of the women they met had such sad life stories, in which rape was just one of many tragic events. In one discussion, two participants working as MP talked about their fantasies of revenge. "I started fantasizing about looking him up, turning into

this masked avenger and attacking him. I didn't do it, though [giggles]" (MD, female).

Both POs and MP described how they had come to avoid certain people, places, situations, and activities.

I don't even watch documentaries anymore, and like, before, I used to read . . . well . . . fact books, but now I don't even read detective novels anymore. Because I only want happy endings and, and love. . . the glass is full . . . I can't take it anymore. (PO, female)

MP more than POs, and women more than men, described avoiding places such as clubs or gender-mixed toilets or even taking cabs. Several said that they had become more afraid that they themselves or someone they knew could get raped. Both POs and MP described situations in which they had gone beyond their professional role to help victims. One nurse described a situation in which social vulnerability and the lack of a social network left one woman with no chance to get help from anyone else. The nurse described how she had escorted the woman to ensure that she got home safely, but in hindsight, she reflected on her own safety in such a situation.

It actually ended up with me going with her . . . to the shelter . . . and when I got home afterwards, I was thinking to myself, "I did this out of pure compassion," but also, "How involved should we actually become?" (N, female)

Discussion

A victim's initial meeting with a professional after sexual abuse or rape can be crucial to her ability to process what happened (Rudolfsson, 2015). Comforting professionals who show empathy and support during disclosure have been associated with improved psychological health among victims (Campbell, 2005). However, professionals who seem cold or disbelieving have been shown to exacerbate the victim's psychological suffering (Ahrens et al., 2010). Initial meetings with professionals are therefore vitally important to the recovery of women who have been raped (Campbell, 2005). This study aimed to further our understanding of the psychological effects and potential difficulties experienced by POs and MP in meeting with women who have been raped. We also aimed to understand professionals' need for support in this context.

Although POs and MP differ in some respects, they also share important similarities. Both POs and MP are first responders and hence among professionals exposed to traumatic material in its rawest form. Previous research has focused mainly on professionals who have, and suffer the effects of, long-term contact with traumatized individuals (Zeidner et al., 2013). This study indicates that first responders are also affected in negative ways, despite their briefer contact with victims. The regular experience of working with victims and listening to traumatic stories may overwhelm the professional's capacity to adapt and cope, leading to psychological changes (Kerswell et al., 2020). The negative emotional effects of such exposure can increase both the risk and the consequences of ST in first responders.

Empathic Responses and Identification With the Victim

All participants described how they felt a strong sense of empathy with the victim. Previous research stresses empathy as an essential resource in meeting with victims (Figley, 1995; Maddox, Lee & Barker, 2011). However, empathic reactions to other's distress also risk the increased emergence of internalizing problems within the professional (Tone & Tully, 2014).

Several participants described how meeting with women who had been raped left them exhausted. Some feared that this might make them grow cold and numb, whereas others admitted that their approach to victims had already changed. With longer experience, several participants had become less emotional and more goal-focused, leading them to become perhaps overly pragmatic, viewing the woman less as a human and more as a source of evidence. Dehumanizing the other in this way might be viewed not only as a way of dealing with exhaustion but also as a way of distancing oneself from the pain and vulnerability experienced by the victim (Vahali, 2015). Thus, the more goal-focused professionals become, the less attention they feel they need to pay to their own or others' emotions. Professionals who do not reflect on the personal consequences of their interactions with traumatized individuals risk not only their ability to treat victims with respect and sensitivity but also their own emotional health.

Professionals' strong empathy in these cases may be attributed to their identifying with the victims, which may contribute to their motivation to help. It might also help victims to feel seen and understood (Bride et al., 2007). All participants described being emotionally affected by their encounters with women who had been raped, which evoked a strong sense of empathy. They gave detailed accounts of the stories they had listened to and stressed their empathetic response as a prerequisite to adequate treatment. Empathy, which motivates a desire to reduce others' suffering, has been described as a strong predictor of helping behavior (Pavey et al., 2012). It has also been linked to positive interpersonal and intrapsychic outcomes such as increased social engagement (Tone & Tully, 2014). Previous research has addressed the importance of empathy in meeting with victims of rape (Maddox et al., 2011). For example, victims who perceived POs as empathetic were more likely to continue with the legal process (Jordan, 2015; Maddox et al., 2011) and disclose more information (Greeson et al., 2014). However, research also shows that empathetic reactions to another's distress can increase the risk of internalizing problems in professionals (Tone & Tully, 2014) and contribute to their sharing the victim's feelings and symptoms (Turgoose et al., 2017). Many participants in our study described often feeling overburdened by empathy. This raises the question of how much empathy professionals can feel for victims of sexual assault before it becomes a burden too large for them to bear.

Participants tended to describe assigning a female professional to respond to a raped woman as "common sense." There seems, therefore, to be a general assumption that women share a common understanding of rape, which comes from shared socialization influences (Martin, 2005). Previous research shows an expectation that female professionals take greater responsibility for victims who are women (Rudolfsson, 2015). In this study, participants of both sexes described a higher identification between victims and female professionals. Therefore, we can assume that female professionals in Sweden are at higher risk of being assigned to

respond to victims of rape and more exposed to ST. This may confirm the finding in previous research that female professionals are at higher risk of developing PTSD symptoms than their male colleagues (Carmassi et al., 2018).

Unlike the male participants, most women in this study described being able to picture themselves in the victim's position. Although our sample is too small for us to draw conclusions, we do offer some thoughts on this difference. Previous research has identified a risk that male personnel can come to identify with the perpetrator rather than the victim (Etherington, 2009). The lack of statements about identification among male participants may therefore perhaps be a response to a fear of identifying with the perpetrator, which could contribute to feelings of guilt (Palmer, 2019). However, female professionals may also identify with the perpetrator. In this study, participants sometimes described their work as making the victim relive the rape. The feeling that one's work forces a woman to relive her trauma can be assumed a heavy burden for the professional to bear.

Increased Fear and Changes in Worldview

The participants described having become increasingly aware of the dark side of society and no longer thinking that the world is a safe place. Several described becoming increasingly wary of men in general, and some even described viewing all men as potential rapists. Previous research has identified changes in worldview as a symptom of ST in professionals (Yaakubov et al., 2020). When their perspective on the world changes, it can be difficult for professionals to hold onto the idea that people are generally good. This can lead to an internal conflict about the essential nature of the world as good or bad (Palmer, 2019). To manage these thoughts, it is common for people to become cynical (Jirek, 2015), and some participants in our study mentioned this tendency. Being ruthless, insensitive, and skeptical about the world—and sometimes the victims—may reflect some professionals' efforts to comfort themselves with some kind of meaning and explanation of the evils of the world (Pearlman & Saakvitne, 1995).

Constantly listening to stories about rape and violence might also lead professionals to develop an altered perception of their own safety and control (Pearlman & Saakvitne, 1995), as described by participants in this study. Due to increased insight into their own risk of rape, women participants were more likely than men to describe avoiding certain places and situations. Some also described how memories could pop unexpectedly even months after a meeting. Such changes in perceptions of the world, avoidant strategies, and intrusive thoughts are similar to symptoms in victims diagnosed with PTSD (American Psychiatric Association, 2013). Those same feelings and changes in perceptions of the world may confirm to professionals that the stories they hear from victims also reflect their own lives. One of the POs discussed how some of her interests had changed over time: She no longer enjoyed documentaries and could only tolerate romantic movies with happy endings. Although this might be related to her frequent exposure to traumatic material, it may also be a sign of survivor guilt, irrational self-recrimination for not having suffered the trauma experienced by another (Palmer, 2019). Such feelings may cause professionals to find it difficult to enjoy the pleasures and comforts of their own lives. As a way to balance the injustice in the world, other participants fantasized about revenge, which may

be viewed as a way for them to gain some of the personal control that their interactions with victims may have disrupted (Pearlman & Saakvitne, 1995). Participants described feeling frustrated and helpless about what the victims had suffered. In one way, this might function to motivate the professionals to help these women, but it may also be a way for them to gain a sense of control over the victims' future. This in turn may reassure them that they can contribute something meaningful through their work and thus feel less helpless and more successful in their work.

Feeling unable to make a difference has been linked to professionals' reduced perceptions of control and role competence (Regehr et al., 2004), and these changes can increase their risk of ST (Walker, 2004). Several participants admitted that they sometimes helped victims outside of their professional duty. Stepping beyond one's professional duties may be seen as benevolent and empathetic, but it may also be viewed as a way to regain a sense of control and professional competence through feeling able to make a difference in the women's lives. Going beyond the professional role, however, can lead to too much engagement and exacerbate preexisting difficulties in creating boundaries between themselves and the victims they work with (Palmer, 2019).

Lack of Emotional and Structural Support

As in previous research in professionals working with women victims of rape (Martin, 2005), the participants in this study described frequent feelings of powerlessness. These feelings were often linked to their inability to offer the victims juridical justice (Turgoose et al., 2017), but they may also reflect a feeling projected on them by the victims (Liotti, 2014).

Although powerlessness can be an empathic response, it can also create difficulties in actually showing empathy (Turgoose et al., 2017). Both POs and MP described feeling frustrated by work that seemed almost in vain, as if they were struggling against a headwind, which we can assume greatly reduces their sense of professional accomplishment. This in turn may cause a sense of hopelessness and ineffectiveness in their work (Stamm, 2010). These feelings in professionals may limit their ability to give victims the help they need, which may in turn confirm victims' beliefs of not deserving restitution (Zinzow & Thompson, 2011). Feelings of frustration and hopelessness can also adversely affect professionals' motivation to continue offering care to women victims, thus exacerbating the cycle of empathy, survival guilt, and helplessness.

Previous studies show that social support can affect professionals' psychological health after they have listened to stories with traumatic content (Kerswell et al., 2020) and the risk of ST can be reduced when professionals have access to professional support (Bégar & Severinsson, 2006; Salston & Figley, 2003). Severinsson and Hallberg (1996) concluded that supervision can help professionals continue to act under stress, have more work motivation, and have a more tolerant attitude toward the people in their care. Thus, supervision and support from employers affect the quality of treatment professionals can offer victims. However, in this study, participants described a lack of both structural and emotional support. Although supervision was available in group settings, it was not always available when it was most needed. Lack of easily accessible support can be a sign of a culture of silence in which emotions are viewed as deviations from objectivity (Jordan, 2015).

This culture can contribute to professionals' feelings of shame and make them doubt whether they have the mental strength to deal with the emotions provoked by meeting with women who have been raped. This may also discourage professionals from reflecting upon or understanding why they experience certain psychological reactions.

There is a general understanding of the "macho" culture of the Police Authority that professionals should handle their emotions on their own (Rich & Seffrin, 2012). In this study, one PO who had filed a report on work-related injury said that asking for emotional support was taboo within the Authority and that colleagues saw him as weak for not coping on his own. A latent culture of silence was also discernable among MP, who also described a lack of emotional support. These participants talked about how they often discussed interesting cases with colleagues but rarely mentioned what it meant to carry the burden of the victim's story. A culture of silence could therefore lead professionals to feel lonely in their work and possibly to believe that they are the only ones who feel and think the way they do. If there is no room to discuss personal experiences, professionals will not only feel they are overreacting and their experiences are unimportant but may also lack being reassured that their feelings are normal and acceptable. Cultures of silence might therefore be considered a risk factor for ST. Previous research has shown that social support after listening to a traumatic event can affect a professional's mental health (Kerswell et al., 2020). Consequently, although a more open culture in health care than in policing may theoretically allow professionals to discuss their feelings from meeting with victims, other structural factors might make that discussion difficult in reality. One important is the lack of time accorded to MP to reflect, which may increase the difficulty they have in expressing their feelings to colleagues.

Lack of emotional and structural support is therefore important to consider as it risks hindering both POs and MP from conducting their work effectively. The need for social support and supervision by employers is crucial: Although some feelings "stick," support and supervision may enable professionals to cope constructively with what has affected them.

Methodological Reflections

Deductive thematic analysis enables the identification and interpretation of themes based on the theoretical interest. It is a flexible approach, making it a useful method for examining the perspectives of different participants, highlighting similarities and differences, and generating unanticipated insights (Braun & Clarke, 2006).

The uneven distribution of men and women in this study reflects the reality that the majority of professionals in policing and health care, both in Sweden and elsewhere, who work with victims of rape are women (Rich & Seffrin, 2012; Statistics Sweden, 2020). Furthermore, two different professions were included in this study. POs and MP have different aims: POs to investigate crimes and MP to care for patients. Consequently, POs do not work in a caring profession, and they are obliged to question all allegations and interrogate both victims and suspects. Because MP aim to care for their patients, we might assume there is also a general idea of caring for each other at work. Thus, MP may be more willing or able than POs to show vulnerability at work.

The interaction between individuals in a focus group can contribute to debates and stimulate participants to remember experiences they might not in individual interviews (Millward, 2006). However, the dynamics of focus groups can also affect how open participants are to sharing their personal experiences. Just as supervision in group settings can make it difficult for some participants to disclose personal information, focus groups can have the same effect. Previous research shows that participants also tend to express thoughts and opinions they think the researcher wants to hear (Randall, Prior & Skarborn, 2006). Therefore, we must stress the possibility that the moderator, being a woman with a background in psychology, could have affected what the participants chose to share, or at least our interpretation of it.

Finally, although the participants in this study gave statements that support the existence of ST, we cannot guarantee that this is the case for each of them. Based on previous research, however, the participants' statements confirm both symptoms and reactions similar to those who have been secondary traumatized.

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