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VICARIOUS TRAUMATIZATION:
Prevention and care for the psychotherapist*

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If we are dealing with shock and trauma in our clients we need to also be prepared to deal with it in ourselves. As the pool of information and practice has grown in the field of psychotherapeutic treatment of trauma survivors we have become more aware of "secondary post-traumatic stress disorder" or "vicarious traumatization" or "traumatic countertransference" as experienced by the therapist in response to working with survivors of severe abuse.

When most of us became therapists, we had no idea what we would be in for. Many therapists working with trauma survivors have witnessed more pain and horror than they could possibly have anticipated or imagined. It is not likely that any of us knew what to expect. We may have expected stories of abuse and human suffering, but now therapists are being exposed to what Steele refers to as "'creative' abuse, creative in the euphemistic sense of being exceptionally sadistic, bizarre, horrendous; sometimes ritualistic, organized, and pre-planned. Survivors recount experiences of being buried alive, physically tortured in unimaginable ways, sexually mutilated and abused, bound and gagged, starved, force-fed (sometimes even involving cannibalism), sleep-deprived, systematically degraded and humiliated, drugged, brainwashed, left alone in utter darkness." None of us has been particularly prepared for confronting such severe abuse.

Steele continues, "As these dimensions of evil and suffering, of meaninglessness and aloneness and annihilation splatter themselves over our comfortable offices, we struggle anew with old existential questions. And our own unhealed woundedness, whatever it may be, is instantly and deeply touched."....."There is a vicious jolt that comes as we hear the unspeakable, as we know the unknowable, as we sit with someone who has experienced the intolerable. What can we do when our carefully constructed answers to the questions of life and death, of good and evil, crumble around us like a house of cards? As therapists we are often charged with evoking the healing of a wounded psyche; this is familiar. But what of that stunned moment when we suddenly realize there is more: when we come to a terrible knowing that we are not just repairing psychological damage, but that we are sitting face to face with a shattered soul? How many of us are prepared for this?"

According to McCann and Perlman, "exposure to the traumatic experiences of victim clients can cause enduring psychological consequences for therapists. Persons who work with victims may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons." This occurs through the alteration or disruption of the therapists' cognitive schemas and imagery system of memory by exposure to traumatic experiences of their clients.

Cognitive schemas refer to mental frameworks including beliefs, assumptions, and expectations about self and world that enable individuals to make sense of their experiences and to interpret events. Traumatic events challenge "three basic assumptions about the world: the belief in personal invulnerability; the view of oneself in a positive light; and the belief in a meaningful, orderly world." (Janoff-Bulman) The therapist's schemas can be continuously challenged by clients' reports of traumatic experiences, resulting in an overall sense of disorientation.

"Therapists who listen to accounts of victimization may internalize the memories of their clients and may have their own memory systems altered temporarily or permanently." (McCann and Perlman) This occurs when the therapist experiences the client's memory through imagery. The imagery system of memory can be altered causing vicarious traumatization. When this occurs the therapist may experience the client's traumatic imagery returning as fragments. These fragments may be in the form of flashbacks, dreams, or intrusive thoughts. Such alterations in memory are usually transient, but McCann and Perlman believe it is more likely to become permanently incorporated into the therapist's memory system when the material is particularly salient to the therapist, relating closely to her psychological needs and life experience, and when the therapist does not have the opportunity to talk about her experiences of the traumatic material.

Many such therapists, experience symptoms that include some combination of anxiety, sleep disturbances, nightmares, poor appetite, numbing, feelings of guilt, a questioning of spiritual beliefs, alienation, demoralization, hypervigilance, restlessness, intrusive images, preoccupation with the content of the abuse, questioning our own safety. Therapists experiencing these characteristics are sometimes unaware and are likely to carry them both in and out of the therapy office. Such conditions can greatly affect the therapist's ability to maintain a therapeutic stance, and without proper care and attention, these experiences can quickly lead to burn out, frustration, and a reduced capacity for empathizing with the suffering and struggles of

our clients.

As therapists we are caregivers. Yet we are also very human, and our ability to support and nurture our clients is directly tied to our own emotional well-being. In working with survivors of trauma, it is very important that the therapist tends to her own secondary trauma. If the therapist's experience is not acknowledged and dealt with, then the therapeutic relationship is likely to suffer due to the therapists need to avoid pain. Denial and countertransference issues will arise in the form of the therapist's need to avoid exploration of the client's experiences. The client may not be allowed to fully process his own feelings or experience. The therapist's denial or avoidance of her own feelings will affect the choices made by the therapist about which areas to explore in sessions and how deeply and intimately the material will be processed. The therapist might focus on such issues as what might have motivated the abuser, rather than the client's experience. When overwhelmed with horror the therapist might becoming intrusive, controlling or overprotective toward the client. Feelings of powerlessness and inadequacy may turn to anger and result in inappropriately encouraging the client to take action, rather than allowing the client to explore his experience and eventually move into appropriate action as part of the healing process.

Therapists in this situation are not going to be able to process and contain their clients' fears and anxieties but will likely work unconsciously to ease their own pain. They may function as if their clients are constantly in a crisis and provide more concrete practical and directive therapy in order to avoid deepening the therapeutic work . A general kind of numbing may settle into each session. Another dreaded reaction to working with trauma survivors is feeling ambivalent, negative, or moral/judgmental feelings toward the client.

As in dealing with other countertransference issues the therapist's confronting her own feelings of aggression, rage, grief, horror, loss of control and vulnerability can provide opportunities in the therapy experience. Our capacity for intimacy and connection with our clients is directly connected to our capacity to experience and tolerate our own painful feelings, images, and thoughts. If we avoid one, we will reduce our experience of the other. Facing our own sense of horror, fear and pain can profoundly enhance the therapist's ability to stay connected, to her own emotions as well as to the client. The therapist's self-esteem and sense of competence will be greatly enhanced by opening up to such a process. It is only through such presence of feeling can real meaning and comfort be found. (Davis and Cramer)

The secondary trauma of psychotherapists and counselors who work with trauma survivors presents a unique set of problems. These problems can be summarized as follows:

1. Often the therapist was a survivor of abuse herself and must reprocess her own memories as she is processing those of the client. Traumatic memories can be re-elicited even if they have been resolved. The therapist can unfairly blame herself when such flash backs occur.

2. Because of boundary issues, the therapist is not able to process a client's horrible memory with friends and family.

3. Because of the stigma connected with trauma work, which includes dealing with incest and cult abuse, it is harder for the therapist to find support in the psychotherapy community.

4. By personality, many therapists tend to be uncomfortable in other than caretaking roles and have difficulty actively seeking support for themselves.

5. It is difficult for the therapist to not feel a sense of failure when working with some victims of trauma who present with chronic, entrenched symptoms that are difficult to treat.

6. The ongoing nature of hearing traumatic memories of one client after another, makes it difficult to reach a place of resolution and completion in regard to our own healing process.

7. Because of the difficulty reaching resolution the therapist may begin to avoid her own pain, resulting in an inability to be present for a client's pain.

8. Because of the possibility of avoidant behavior that can go along with therapist's experience of post traumatic stress, it is more difficult for the therapist to maintain boundaries and resist acting out or discharging in inappropriate ways. One common form of acting out, has been to become directive and push the client into taking overt action toward the abuser, rather than allowing the client to make her own decisions.

Recently, I was involved in the writing of a book for psycho- therapists working with people with HIV by the University of California in San Francisco AIDS Health Project. The chapter I co-wrote with a colleague in Austin is on Multiple Loss for the Therapist. Only in reviewing the previous seven years of working with clients with HIV, did I realize the level of denial I was experiencing when I was going through it. In many ways I had become numb and hadn't realized it. I had gained thirty pounds, had become more isolated and had acted out in ways that were not generally typical. It took continual processing as I was writing the chapter to begin to

grasp the impact of losing over one hundred friends and clients, one after another with no time between to complete a grieving process. As we approached the chapter, my colleague was able to talk about what he had done to take care of himself, while I came more from the perspective of what I hadn't done to take care of myself.

In discussing how to deal with the impact of secondary trauma perhaps I can teach from my mistakes as well as my discoveries for successful coping. It is hoped that the reader, can sort through and glean what is personally beneficial in managing your emotional well being as you explore new depths with your clients.

Most of us who are therapists, are in this field because we want to help others, but at some point along the way have realized the ongoing growth we experience from our work and through our relationships with our clients. The need for developing coping strategies for the therapist is pretty clear. Methods for coping with the ongoing exposure to traumatic experiences of clients are for the the emotional survival of the therapist and to enhance the client therapist relationship. We might also expect a great deal of personal growth in the therapist as she develops these coping strategies. It is in what we do to be more available to our clients that we can find our own healing.

It is important that we are aware of our needs and feelings and that we are tending to those needs and feelings. Without that clarity it is more likely that we will get into situations with our clients where we are indirectly getting them to meet our needs and which means they don't get to fully be themselves. Our lack of attention to ourselves leaves greater opportunity for acting out, loss of regard for professional boundaries, and certainly stagnation of the therapy.

SOME IMPORTANT COPING STRATEGIES:

Be aware of your own limits. Because of the intense drama and life/death issues involved in this work it is easy to get overextended in frequent phone calls, waving of fees, getting extra consultation, etc. Setting limits on how many dissociative clients one can see, or how low to slide a fee, or how often to wave a fee can touch into some therapists' issues, of being selfish or not altruistic enough. For others the illusion they can do it all, may be a way they are defending against the feelings of horror and powerlessness to which we are prone in this work. It is necessary to reinforce that being clear with ones own limits can help you be more present with your clients when you are with them, extend the length of your availability to this line of

work, and is good modeling for clients who could benefit from increasing their own skills in setting limits and taking care of themselves.

Be vigilant about checking in with yourself to help prevent a pattern of avoidance, and stay aware of your own conflict areas or unresolved traumas that are reactivated by the therapeutic process.

Maintain balance between your personal and professional lives, as well as the kinds of clinical cases you take.

Tend to physical self nurturing, such as exercise, recreation, nutrition, rest, and sleep.

Be careful not to isolate yourself. If the therapist is already susceptible to such issues, the awareness and carrying of such stories of horror and evil can cause the therapist to feel tainted and uncomfortable around others.

Find ways to express and discharge feelings on a regular basis. As bioenergetic therapists we know that this can enable the therapist to move to deeper issues that the storage of feelings suppresses and it can help prevent pent up tension leading to physical problems.

Frequently examine feelings and beliefs about good, evil, and injustice. Many therapists have found themselves questioning previous beliefs and perspectives of the world. Previous, more idealistic frameworks or "cognitive schemas" have been shaken. It is helpful to consciously explore and find a schema that incorporates the new information, such as the existence of evil, but still provides some framework out of which the therapist may organize her world. This exploration will likely include an acknowledgment of the therapist's own sadistic or dark side.

Create a professional support system for yourself through a therapists' support group, your own therapy, and through supervision. It is particularly important to seek out contact with other professionals who work with abuse survivors. A colleague once remarked on how we are so focused on creating "holding" for our clients we forget to "hold' each other. Setting up such a professional support system is the responsibility of the therapist.

What makes the work worthwhile for you? McCann and Perlman refer to "a tremendous sense of personal meaning that evolves from knowing that we are involved in an important social problem by making a contribution toward ameliorating some of the destructive impact of violence on human lives. For some of us, an outcome of our enhanced awareness of social and political conditions that lead to violence has been greater social activism. Other positive effects include a heightened sensitivity and enhanced empathy for the suffering of victims, resulting in a deeper sense of connection with others; increased feelings of self-esteem from helping trauma

victims regain a sense of wholeness and meaning in their lives; a deep sense of hopefulness about the capacity of human beings to endure, overcome, and even transform their traumatic experiences; and a more realistic view of the world, through the integration of the dark sides of humanity with healing images. Although we may be sadder but wiser, it is important to acknowledge the many ways this important work has enriched our own lives as well as countless others."

Compassion is our ability to be with others in their pain. We can only be with others, as much as we can be with ourselves.

* This is a slightly revised "Vicarious Traumatization: Prevention and Care for the Psychotherapist," in *Shock and Trauma: A Bioenergetic Approach,* Training Journal of the Pacific Northwest Bioenergetic Conference, ed. Miller, Barbara, 1993.

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