

Shared Trauma: The Therapist's Increased Vulnerability

Karen W. Saakvitne, Ph.D.

When both therapist and client share a traumatic event, there are multiple levels of vulnerability to traumatization for the therapist. Our personal vulnerability is not only a backdrop for our clinical work but also an acknowledged fact in many therapeutic relationships, a situation that changes the frame of the work. In addition to clinical challenges, shared trauma increases a therapist's vulnerability to vicarious traumatization; VT is defined as the negative transformation of the therapist's inner experience as a result of his or her empathic engagement with and responsibility for a traumatized client. Emphasizing the importance of awareness, self-care, meaning, and community, the article summarizes important steps to anticipate, address, and transform the therapist's experience of vicarious traumatization.

I RETURNED FROM A THREE-WEEK SUMMER VACATION ON SEPTEMBER 10, 2001. The week before, I had launched my five-year-old daughter into kindergarten. On her first day of school, she was elated, proud, and excited, and I cried. My tears held a mixture of pride, loss, and fear. Her world had just become larger, and I had less control over it. I worried about her vulnerability in a world that would not be paying close enough attention to her innocence.

And that was *before* September 11. On my second day back from vacation and her fourth day of kindergarten, the world, as I had known it, changed. The scrim of denial that allows us all to maintain some illusion of invulnerability was ripped down. The loss of the widely

Karen W. Saakvitne, Ph.D. is Clinical Director of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, in South Windsor, CT and Northampton, MA. She is a member of the American Psychological Association's Advisory Committee on Colleague Assistance (ACCA) under the Board of Professional Affairs.

shared belief in our national invulnerability to such an attack was a loss of innocence. We lost, too, our freedom from fear.

I sat in a session at 11:00 that morning and felt shared grief and horror with my client. I did not feel particularly like a therapist. Moments earlier I had been weeping. I struggled to find my familiar place as a therapist; the familiar was gone. When, midway into the session, my client asked, "So, where do we go from here?" I asked, "Well, how were you doing before you heard of the attacks?" The question seemed ridiculous, and yet brought us back to the familiar and located in time (8:45 a.m.) both the familiar and the loss of it.

As a specialist in trauma, I am aware of the particular vulnerability faced by therapists who work with survivors of traumatic life events. When both therapist and client share a traumatic event, however, there are multiple levels of vulnerability to traumatization for the therapist. *Direct, or primary, traumatization* refers to the direct effects of exposure to traumatic events, as perceived and experienced by you. *Secondary traumatization* refers to the effects of experiencing the traumatization of others whom you love and for whom you feel responsible. *Vicarious traumatization* refers to the transformation of your inner self as a result of your empathic engagement with traumatized clients in the context of a helping relationship (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995).

Many clinicians are currently experiencing multiple levels of traumatization. Our personal vulnerability not only is a backdrop for our clinical work, but also is an acknowledged fact in many therapeutic relationships, a situation that changes the frame of the work. When in distress or feeling vulnerable, therapists commonly strive to protect their clients from that information (and themselves from the concomitant exposure). At the very least, a therapist can usually make a considered choice about disclosure (Gerson, 1996). With a shared tragedy, the frame of our work shifts. We are forced to remain consciously aware of our own vulnerability. When our vulnerability is both perceived by our patients and experienced by us, often we feel deskilled and sometimes guilty or ashamed. How does that personal awareness change our availability, our ability to track the patient's affects, our vulnerability to responding in concordant or complementary ways to the transference? The work of relational psychoanalytic treatment just got harder.

What is it like to do this work in the aftermath a tragedy? Over the weeks after September 11, I was aware of my greater emotionality. I

was stunned at how frequently I became teary in response to my patient's material. At the same time, I found myself feeling more connected to patients who were angry than to those who were frightened. I recognized my familiar defensive rage at circumstances in which I feel intimidated or made to feel afraid. Patients who expressed grief stirred the depths of my sadness, and I had to struggle at times not to flee emotionally. I was also chronically exhausted, in fact, bone tired. It took me several weeks to realize that not only was I doing additional crisis response work, performing ongoing clinical work, and trying to tend to the emotional well-being of my staff and colleagues, but I was also coming home to very young children whom I was protecting from information and imagery. I had left no adult space in either my professional or personal lives to attend to my emotional overload and needs. I hired a babysitter so I could watch a tape of the service at Yankee Stadium and cry. The night before our biannual staff retreat, we added a two-hour debriefing, like the ones we had been offering to so many others. We agreed that we needed a facilitator to allow us to be full participants, and to stave off our defensive caregiving responses.

An added dimension to my experience of the trauma of terrorism comes from my work with patients who are themselves survivors of childhood abuse and neglect, often in the context of what Judith Herman (1992) calls a "familial climate of pervasive terror" (p. 98). As I experienced the threat of terrorism in my world, my empathy for them and rage about the chronic terrorism of some childhood abuse intensified. When one patient admitted, with self-loathing and guilt, that she "kind of admired the terrorists" because they stood up to a country whose power they hated, I had no trouble understanding. She thought she was a monster; I thought she was angry and enjoying a fantasy of revenge. I suggested "If you imagined the Towers were your father, I could imagine it would feel great to fly a plane filled with airplane fuel into him." She had not consciously made any connection between her unspeakable childhood experiences and her "unspeakable" reaction to the attacks.

Elsewhere, my colleagues and I have framed psychotherapeutic work with trauma survivors as a process of *risking connection* (Saakvitne et al., 2000) in which both patient and therapist must risk deep emotional connection, both intrapsychically, within themselves, and interpersonally, with one another. The Risking Connection curriculum teaches that a relationship can be therapeutic whether it lasts for five

minutes or fifteen years, when it offers respect, information, connection, and hope (RICH). A traumatized person is helped when offered respect for his or her experience and adaptations, rather than a pathological label. The process of healing is aided when she or he is given information about expectable responses to traumatic events and about available resources. The existential isolation that is part of traumatic loss and despair is alleviated when a survivor is offered genuine human connection with someone who shows a willingness to accept and acknowledge strong emotions and painful accounts of traumatic events. A survivor in the midst of overwhelming grief and hopelessness is helped when offered sincere hope for healing and finding meaning even in the face of that which seems meaningless.

These are our therapeutic tasks, and this time we need to acknowledge the need to accomplish the same for ourselves. Because of our multiple levels of vulnerability, we, too, need respect, information, connection, and hope. Where do we turn? Can we, the analytic community, create a culture that recognizes all therapists' vulnerability and need for active support in doing the challenging work that needs to be done? I believe we can and must. The analytic tradition of ongoing consultation will hold us in good stead. None of us should be doing this work alone. Our tradition of personal analysis or psychotherapy helps us accept our own vulnerability.

What works against us is our tendency to emphasize the intellectual over the emotional and spiritual in our own process. Further, our unrealistic expectations for ourselves and each other about professional detachment and "neutrality" can create a barrier of shame that prevents the honest disclosure of the pain and anxiety of the work. We need to deconstruct the shame that has silenced so many of us in our analytic communities and be willing to speak the language of feelings, rather than constructs, and to express fears and doubts, rather than solely analytic formulations.

Vicarious traumatization (VT) is the negative transformation of our inner experience as a result of our empathic engagement with and responsibility for traumatized patients (Saakvitne, Pearlman, and the Staff of the Traumatic Stress Institute, 1996). When the traumatic experiences are shared, we are even more vulnerable. Each of us responds to traumatic events through a personal lens shaped by our previous experiences, our most salient psychological needs, and our unique emotional style. When we add to that response our empathic engagement with each of our patient's unique experiences of the

trauma, the scope of the unbearable keeps getting larger. When your patient reports a source of anxiety you have not yet considered, when your patient describes the known or imagined experience of a particular victim or survivor that was hitherto unknown to you, when your patient's adaptations conflict with your defenses or coincide with your greatest anxieties, your emotional load and the task of psychological coping increases.

Vicarious traumatization is based on the trauma theory called constructivist self development theory (McCann and Pearlman, 1990b; Pearlman and Saakvitne, 1995). VT affects the same general aspects of self that are affected by traumatic life events: self capacities (affect management, object constancy, self-worth), frames of reference (identity, world view, spirituality), basic beliefs and psychological needs (safety, trust, esteem, intimacy, and control), and realms of perception and memory (verbal, somatic, visual imagery, emotional, relational, and behavioral). The most devastating impact of vicarious traumatization is in the realms of hope and meaning, specifically in cynicism and pessimism. The dangers lie both in direct negative effects (intrusive imagery, disrupted beliefs) and in our defenses against the pain of cherished beliefs forever changed (numbing, overgeneralized negative expectations, cynicism).

"How am I doing?" needs to be a regular question for each of us to ourselves. As we assess our own psychological health and well-being, it is important to emphasize strategies of self-protection and healing that can support us as therapists and diminish the negative impact of our work. These strategies fall into three categories: protection, self-care, and transformation.

Protection and anticipation are best achieved by being aware of the dangers and signs of vicarious traumatization, maintaining a reasonable balance among work, rest, and play as well as within your work life, and nurturing ongoing connection with others who can support you in your work. The goal here is to respect the difficulty of our work and therefore pay attention to the choices that affect the quality of our work-life.

Addressing vicarious traumatization requires good self-care skills. Keeping ourselves healthy is essential if we are to face the enormous stress and physical and emotional toll of the work. Additionally, we need to practice self-nurturing strategies, that is, engaging in activities we actively enjoy and find pleasurable. Because trauma is always about loss and pain, we need to go out of our way to create a balance and

make room for joy and sensory pleasure. We also need to have means for escape. In doing the work we do, we express our willingness to face that which others may wish not to hear or may deny. To balance the cost of bearing witness, we need opportunities that allow us to turn away, to escape from harsh reality into fantasy, imagination, art, music, creativity, and sheer foolishness.

Finally, and most important, is the work of transforming vicarious traumatization. This work focuses on meaning, perspective, and community. Because healing psychological trauma requires the conscious examination of meaning (Frankl, 1959; Janoff-Bulman, 1992), so the amelioration of vicarious traumatization requires creating meaning and infusing everyday activities with meaning. This process should include an examination of the meaning of our work to us. Why do we do this hard work? What are the costs and what are the benefits of the work to each of us? Keeping perspective often requires that we challenge some of our overgeneralized negative assumptions. There is good as well as evil in the world. There are random acts of kindness as well as senseless violence. We need to pay attention when our perspective becomes jaded, tinted with negativity; we must work to bring the full complexity of contradictions and nuance into view. Finding community transforms the existential isolation that comes with despair and grief. Communities offer connection with shared visions, beliefs, hopes, dreams, and goals. They speak to the potential creativity and constructive outcomes that result when humans work together to bring about positive change.

As a therapeutic, analytic community, we are working together to address the terrible psychological trauma that followed the attacks of September 11 and ensuing events. We are making a difference and will continue to be an important force in the healing process. At the same time, this work will change us and our experience of the tragedy. We need to attend to our increased vulnerability, and we need one another to create a community of support for all of us doing this important work.

REFERENCES

- Frankl, V. (1959), *Man's Search for Meaning: An Introduction to Logotherapy*. New York: Washington Square Press.

- Gerson, B., ed. (1996), *The Therapist as a Person: Life Crises, Life Choices, Life Experiences and Their Effects on Treatment*. Hillsdale, NJ: The Analytic Press.
- Herman, J. L. (1992), *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*. New York: Basic Books.
- Janoff-Bulman, R. (1992), *Shattered Assumptions: Toward a New Psychology of Trauma*. New York: Free Press.
- McCann, I. L. & Pearlman, L. A. (1990a), Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *J. Traumatic Stress*, 3:131-149.
- & ——— (1990b), *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation*. New York: Brunner/Mazel.
- Pearlman, L. A. & Saakvitne, K. W. (1995), *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: Norton.
- Saakvitne, K. W., Gamble, S. G., Pearlman, L. A. & Lev, B. L. (2000), *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*. Lutherville, MD: Sidran Press.
- Pearlman, L. A. & the Staff of the Traumatic Stress Institute (1996), *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: Norton.

Traumatic Stress Institute
22 Morgan Farms Drive
South Windsor, CT 06074
KWSTSI@snet.net

