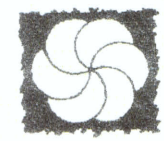
TRAUMA AND THE THERAPIST

Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors



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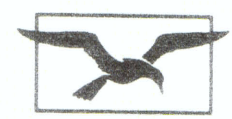

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Vicarious Traumatization: How Trauma Therapy Affects the Therapist

TRAUMA THERAPY profoundly changes the therapist. We give up our familiar way of being and beliefs about the world when we embark on this work with survivors of traumatic life events. These changes are both inspiring and disturbing, involving gains and losses. Rarely do therapists enter the field of trauma therapy with full understanding of the implications of their choice. This chapter describes the impact of vicarious traumatization on the self and life of the therapist.

VICARIOUS TRAUMATIZATION: THE CONCEPT

Vicarious traumatization is a process through which the therapist's inner experience is negatively transformed through empathic engagement with clients' trauma material (McCann & Pearlman, 1990a). While we acknowledge here and in chapter 19 the many rewards of doing trauma therapy, the concept of vicarious traumatization focuses specifically on the negative aspects of the transformation. The therapist is a witness to his clients' traumas, through their vivid descriptions of traumatic events, reports of intentional cruelty and sadistic abuse, and experiences of reliving terror, grief, and yearning. He is both a witness to and a participant in traumatic reenactments within and outside of the therapy relationship.

Some aspects of vicarious traumatization, such as experiencing intrusive imagery, are more likely to be present earlier in the therapist's work with survivors. Others, such as changes in frame of reference, occur over time, after extended empathic engagement. Just as the task of psychotherapy is to contextualize events in order to understand their process, understanding vicarious traumatization requires that the therapist first notice it and connect it to its context, his work. Like countertransference, vicarious traumatization incorporates both a therapist's affective response to this emotional exposure and his conscious and unconscious defenses against those affects. Unlike countertransference, vicarious traumatization refers to the cumulative effect of doing trauma work across clients and to its pervasive impact on the self of the therapist.

Vicarious traumatization results in profound disruptions in the therapist's frame of reference, that is, his basic sense of identity, world view, and spirituality. Multiple aspects of the therapist and his life are affected, including his affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and experience of his body and physical presence in the world.

Vicarious traumatization is a natural response to a very specialized kind of highly demanding work. Just as survivor clients have developed various styles of protecting themselves as a result of childhood victimization, so do therapists develop styles of protecting themselves from repeated exposure to trauma material and traumatic reenactments in the work. Unfortunately, these adaptations are not necessarily all in the best long-term interest of the therapist, the therapy, or the client.

Vicarious Traumatization: What It Isn't

Unlike countertransference, vicarious traumatization is not specific to one client or therapeutic relationship; rather, it takes place over time, across clients and therapeutic relationships. While there is some overlap with burnout (Gamble et al., 1994), vicarious traumatization is not simply "emotional exhaustion resulting from the stress of interpersonal contact" (Maslach, 1978, p. 56), nor is it a result of the gap between our expectations and aspirations on the one hand and the depleting conditions of the workplace on the other (Suran & Sheridan, 1985). Vicarious traumatization differs in its conceptual basis from "secondary traumatic stress disorder," "compassion fatigue" (Figley, in press), "traumatic countertransference" (Herman, 1992), and the observation of post-traumatic stress symptoms in therapists (Lindy & Wilson, 1994); specifically, vicarious traumatization has its foundation in a constructivist personality theory. Unlike the other constructs, vicarious traumatization emphasizes the role of meaning and adaptation, rather than symptoms. Secondary traumatic stress disorder and traumatic countertransference have their foundations in a symptom-based diagnosis—post-traumatic stress disorder (APA, 1994)—and thus focus primarily on a constellation of symptoms. Yet all of these concepts are related to vicarious traumatization in various ways.

Vicarious Traumatization: What It Is

Vicarious traumatization evolves from the complex interaction of central aspects of the individual therapist with aspects of the work (described in chapter 14). Its effects will be unique in each therapist, depending on his personality, defensive style, and resources. The concept of vicarious traumatization is based in constructivist self development theory (CSDT), a developmental, interpersonal theory explicating the impact of trauma on an individual's psychological development and adaptation (see chapter 3 and McCann & Pearlman, 1990b). Our understanding of vicarious traumatization is based in a growing empirical foundation (Gamble et al., 1994; Hollingsworth, 1993; Pearlman & Mac Ian, 1994; Schauben & Frazier, in press), extensive clinical and supervisory data, and discussions with trauma therapists and others who voluntarily enter the world of trauma survivors around the world.*

Given our understanding of psychological trauma and the self and of the interpersonal therapeutic process, from a theoretical perspective, vicarious traumatization is inevitable. It is unique to trauma work and its effects are specific, pervasive, and predictable according to its theoretical foundation and the psychology of the individual therapist. The effects of vicarious traumatization are widespread; its costs are immeasurable. We carry our experience of vicarious traumatization far beyond our therapy space. Because it changes the self of the therapist, it will inevitably affect all of our relationships—therapeutic, collegial, and personal.

Vicarious traumatization can leave the therapist serious, cynical, sad. He may develop an increased sensitivity to violence, or be prone to bouts of grief and despair for humanity. It can affect his ability to live fully, to love, to work, to play, to create. Unaddressed vicarious traumatization can lead the therapist to leave the field, whether because it sets the stage for burnout (Raquepaw & Miller, 1989), because of the therapist's lost sense of identity as an effective helper (Horner, 1993), or because of the demoralization

*Vicarious traumatization can affect anyone who engages empathically with trauma survivors—journalists, police, emergency room personnel, shelter staff, prison guards, clergy, attorneys, researchers, etc. Because of this book's focus on psychotherapists, our discussion is specific to vicarious traumatization in therapists.

and "soul sadness" (Chessick, 1978) that characterize the spiritual damage of vicarious traumatization.

The effects of vicarious traumatization may be permanent. We have experienced these effects ourselves and we observe them in trauma therapists with whom we work. In addition, in our research study of 188 trauma therapists (Pearlman & Mac Ian, 1994), we found significant disruptions in beliefs about self and others as well as distressing psychological and somatic symptoms that resulted from their clinical work with trauma survivors.

At the same time we are convinced that the effects of vicarious traumatization are modifiable when addressed actively (Pearlman & Saakvitne, in press). In the last section of this book, we discuss ways to moderate the impact of the trauma material to which one is exposed and ways to modulate vicarious traumatization.

Effects of Vicarious Traumatization on the Therapist

In general, the therapist may experience many of the same signs and symptoms in himself that his client experiences, but at subclinical levels. These include symptoms of post-traumatic stress disorder (as observed and elaborated by others including Lindy & Wilson, 1994), in addition to other symptoms of anxiety and depression.

CSDT delineates aspects of the self that may be impacted by trauma. Parallel to our understanding of the impact of trauma on a client is the impact of vicarious traumatization on specific areas within the therapist. Some therapists will find certain aspects of the work more difficult and impactful than others; some will be more likely to experience disruptions in one area than others. These changes then color the therapist's experience and perception of all of his life experiences.

Frame of Reference

Perhaps the most disturbing and enduring alteration for the trauma therapist is the inevitable transformation in his identity, world view, and spirituality. These components of an individual's frame of reference provide the lens through which he views, experiences, and interprets his world. Any change in frame of reference reverberates throughout the self. Like vision, our frame of reference is the pane through which we view ourselves and our world. As our vision changes, we lose clarity and the ability to recognize familiar objects, and our perceptions change. While we can get corrective lenses, something is lost. We will now be conscious of the need to make

adjustments as we view our world. We accommodate to the changes, but we no longer take our healthy eyesight for granted.

Identity

Vicarious traumatization causes disconnection from one's usual experience of oneself. Whenever a specific aspect of identity is challenged, the experience of oneself can be one of "not me." This alienation from oneself invariably translates into a sense of unrealness, affective numbness, and distance from others. It leads to rethinking one's basic beliefs about identity, role, and self-worth.

Many who become therapists consider themselves warm, optimistic, and compassionate people. A therapist may experience surprise and shame at his countertransference responses, especially if they include sadomasochistic impulses, sexual arousal, voyeurism, murderous vengeance (Wilson et al., 1994). A therapist who hears himself making callous or cynical retorts to clients or colleagues, has dreams in which he is engaging in sadistic behavior toward his clients' perpetrators or his clients, or finds his mind creating traumatic fantasies can feel alienated from himself.

Another identity issue for trauma therapists arises when a trauma therapist who is not aware of a personal abuse history asks himself, "Am I a survivor?" When clients come to therapy without conscious awareness of their abuse histories and we witness the emergence of this knowledge, we may struggle with doubt or nagging questions about our own early experiences. Whatever the outcome, this very process calls one's identity and key relationships into question.

Similarly, work with survivors of sexual abuse forces each therapist to examine his or her gender identity, what it means to be a man when so many men are perpetrators; to be a woman, when women have been victimized repeatedly throughout time and across cultures; to be a mother, as awareness of maternal abuse of children grows. A therapist will ask himself about his vulnerability to abuse and his capacity for cruelty and exploitation (Krystal, 1968). These questions may shake to the core long-standing beliefs about one's identity and self-worth.

Hearing about sexual abuse affects the therapist's sexual experience and integration of his sexuality into his identity. What does it mean to enjoy one's sexuality, to feel sexy or erotic, when so many do not have access to these feelings? What does it mean to enjoy sexual intimacy when so many people have been terrorized and abused sexually? These thoughts and feelings may emerge during the therapist's sexual activity with his partner. The impact then of vicarious traumatization on the therapist's intimate relationships and personal life is disturbing (Maltz, 1992). He may not

know how to explain it to his partner, particularly when requirements of confidentiality prohibit detailed discussion, and the intimacy, intensity, and process of psychotherapy is little understood by those outside the field. These dilemmas press the therapist's identity as an open, sharing partner in an intimate relationship.

Equally basic to one's identity is one's sense of his body. It is all too easy to move into one's head, to become a thinking rather than a sensing creature, in order to manage the onslaught of emotions connected to trauma therapy material. It is not uncommon for trauma therapists to withdraw from their own sensuality as an unconscious way of protecting themselves from their sexuality or from strong feelings. Therapists can dissociate from their bodily experience within and outside of sessions. There is a danger in this strategy. Therapists cannot afford to lose track of who they are; one's body and bodily experiences are a core aspect of oneself in the world. The experience of childhood sexual abuse has a profound impact on the survivor's relation to her body (Attias & Goodwin, 1993; Saakvitne, 1992; van der Kolk, 1994). As a therapist explores these issues with clients, his awareness of and feelings about his body can change.

Over time, a therapist may rethink another aspect of his identity: what it means to be a trauma therapist. He may begin to wonder why he does this work, or question his competence (Herman, 1992; Putnam, 1989) and efficacy. Therapists may feel isolated when in social situations people recoil from them when they answer the innocent question, "What kind of work do you do?" Remembering that people's responses are part of their own denial and their need to distance from the possibility that trauma can touch their lives is helpful. Yet a trauma therapist then lives with the same silence and isolation his clients experience when they tell or choose not to tell their stories.

Our public identity as trauma therapists can also prevent us from taking a break from work. While some may recoil, others will pursue us with a morbid fascination, pressing endless questions about their friends, families, sexual abuse cases in the news, or about the work and its impact on us. A prominent colleague reported that she now tells people at parties, "I'm an interior designer." Another says he is an actuary. These encoded responses allow them to enjoy themselves in social situations without spending the evening talking about trauma.

When one's professional identity is a central component of one's overall identity, as it often is, these disruptions are severely distressing. To combat feeling uncertain about one's professional identity, a therapist may cling to his professional persona in private life, which creates a barrier to intimacy in interpersonal relationships. It is an impossible dilemma when the work which sustains someone is also harming him.

So many trauma clients live in a netherworld between life and death, in which thoughts of death serve a self-soothing function—the only imaginable release from the pain of living. As therapists, exposure to and participation in that tension exacts a toll from us. Preoccupation with our clients' distress, their grief, and their terror can interfere with our ability to engage fully in our own life experiences. This preoccupation may serve to give us a semblance of control when in fact we have little control over our clients' choices. On the other hand if we do not feel preoccupied, we may question our identity and worth as therapist, or fear we have abandoned our clients.

When unrecognized and unattended, this state of affairs can make the vicissitudes of a therapist's own life seem overwhelming and unmanageable—or trivial and insignificant. Without one's usual anchor of identity, it is difficult to accommodate new information, to integrate change. The therapist may feel overwhelmed by his personal life when its demands are added to the baseline of pain or despair he carries in his heart every day. Each of us chooses this work for particular and personal reasons; survivor therapists may carry both a higher tolerance for painful feelings and a greater capacity for empathy. These characteristics can increase our vulnerability to vicarious traumatization.

World View

The therapist's perceptions of the world, of how and why things happen, of people in general, and his values, moral principles, and life philosophy are inevitably challenged by working with adult survivors. The trauma therapist may feel confused, sorrowful, and often angry as his old world view no longer holds his experience; "no explanation integrates this new reality" (Wilson et al., 1994, p. 42).

As the therapist listens repeatedly to tales of intentional abuse of children, he may feel overwhelmed by the scope and prevalence of child abuse and cruelty. He may question the utility of addressing the aftermath of this massive social problem in individual psychotherapies. Yet when the therapist loses sight of the profound difference he and a single relationship can make, he has lost his therapeutic tools and zeal. This change in world view defeats the therapist's greatest therapeutic gift, his belief in the process and hope for healing.

Some questions which indicate a disrupted world view include, "Is every client a survivor of childhood sexual abuse?" "How can people be so cruel to one another?" "Are people fundamentally self-serving or evil?" The trauma therapist may find himself wondering for the first time whether people he knows and loves are victims or perpetrators. He may feel suspicious of every parent he sees with a child in a store or at a park.

Sadistic abuse can be administered in "small, hidden concentration camps created by tyrants who rule their homes" (Herman, 1992, p. 3), in homes where childrearing takes place in a "malevolent developmental context" (Gelinas, 1994), and in cults by organized groups using satanic rituals (Sakheim & Devine, 1992a). Such abuse can elicit a wide range of responses in the therapist. In addition to our countertransference responses, we are also left with incredulity that people are capable of such repeated acts of horrific cruelty and violence; an alteration of world view to encompass these behaviors is inevitable. Furthermore, if we are not appalled, we need to question the possibility of vicarious traumatization. At a trauma discussion group meeting, the presenter asked if people would be upset if he described some satanic ritual abuse material as part of his case presentation. A participant said, "I hope so."

This world view disruption also leads us to experience what was once ordinary in new ways. Listening to a parent harshly chastise his child in the grocery store, once an annoyance, becomes painful and perhaps even terrifying for the vicariously traumatized therapist who may wonder what this child will endure when alone with her parent. Visiting a pet store now may be followed by a rush of horrific imagery rather than gentle compassion for a fellow creature or loving awareness of the appealing animals.

The realities of those who relate to others through violence chip away at our tenuous belief in what Freud called "the thin veneer of civilization" (Freud, 1930). In defense, we can substitute a veneer of cynicism which can itself be unsettling. Within social learning theory (Rotter, 1954), cynicism is conceptualized as overgeneralized negative expectancies. We can shift from beliefs such as "Sometimes people do terrible things" to "People are terrible"; from "Parents can hurt their children" to "Parents are dangerous." These shifts reflect a profound loss of optimism, hope, and companionship with humanity, and an emotional constriction that can infuse and severely narrow one's life. A therapist may experience a loss of emotional spontaneity, generosity, and vulnerability that will deeply affect both his intimate relationships and personal spirituality.

Our life philosophies, including our values and moral principles, are called into question as we encounter the cruelty one person can intentionally inflict upon another. Therapists who enter the field in large part motivated by humanitarian values can find themselves filled with murderous wishes and fantasies directed at some perpetrators of childhood sexual abuse. Those who held a fundamental belief that no one should be harmed intentionally may be horrified at themselves as they struggle with their rage at perpetrators of sadistic sexual abuse.

Spirituality

The pathognomonic sign of vicarious traumatization is the disruption to the therapist's spirituality. We use the term spirituality broadly to encompass hope, faith, joy, love, wonder, acceptance, forgiveness, gratitude, creativity. Neumann & Pearlman (1994) have developed a psychological framework for understanding spirituality; in brief, we understand spirituality as an inherent human capacity for awareness of an elusive aspect of experience. The components of spirituality include beliefs about nonmaterial aspects of experience, about meaning and hope, about connection with something beyond oneself, and about awareness of all aspects of life.* These aspects of experience are invariably disrupted by trauma; so too are they disrupted by vicarious traumatization. We then struggle to find a source of hope to offer our clients in their work, and for ourselves and our loved ones.

As trauma therapists, our most subtle sensibilities are vulnerable to disruption. The work continuously calls into question issues of meaning; it is easy to join our clients in a state of meaninglessness or nihilism. Yet our "will to meaning" (Frankl, 1959) is essential to our psychological survival in the face of trauma. Thus, this aspect of vicarious traumatization is particularly insidious and dangerous to the therapist. We can easily enter a state of hopelessness or despair (Dyregrov & Mitchell, 1992; Fischman, 1991; Herman, 1992; Margolin, 1984; Wilson et al., 1994). We may feel profound existential isolation and loneliness (Moustakis, 1961). While we may disagree with our clients' beliefs about the world on the basis of our own experience, we can feel their despair. We may then experience confusion and helplessness. Scurfield (1985) warns that those who work with Vietnam veterans will face the darkest side of humanity, and be forever transformed by that experience. In fact, the precursors to the concept of vicarious traumatization came out of the examination of therapists' experience of doing psychotherapy with Vietnam veterans, whose material often contained graphic accounts of war atrocities and personal loss (Haley, 1974), and therapists' experience of working with survivors of the Nazi Holocaust (Danieli, 1982).

Emotional numbing is both a response to painful feelings, such as horror, grief, outrage, shock, and rage, and a sign of vicarious traumatization. The defenses against painful feelings are also part of the effects of vicarious traumatization (just as countertransference reflects both feelings and de-

*A copy of the Life Orientation Inventory, developed to assess disruptions in these four areas, is in the appendix.

fenses against those feelings and related conflicts). A therapist's insight and attunement to his innermost thoughts and feelings and willingness to be open to all aspects of life can diminish as he pulls back in order to protect himself. The defenses employed to protect oneself from knowledge of people's capacity for cruelty, of the agony and terror of young children who are being molested, of the systematic sadism of those engaging in ritualized destructive cult activities have their own costs. As a therapist comes to rely on denial, intellectualization, isolation of affect, dissociation, and projection, his capacity to connect to himself and others will diminish. This selective focus narrows a person's most subtle human sensitivities and represents a shift in his spirituality.

Self Capacities

Self capacities allow an individual to maintain a positive sense of self-esteem and a consistent sense of identity and to manage and modulate strong affect. When these capacities are impaired by vicarious traumatization, the therapist can be overwhelmed with dysphoric feelings, self-criticism, and anxiety. He may find it more difficult to be alone without feeling anxious, depressed, or lonely; to tolerate and integrate strong feelings; to hold on to images of loving others; to enjoy activities and people previously valued. The therapist may feel sorrow, grief, anger, or rage. His tears may be very close to the surface much of the time. He may feel unloving or unlovable. He may avoid difficult movies or the news because the experience of others' suffering is so much more intense when one's self capacities are impaired.

Impairments in self capacities imply difficulty in self-soothing. The traumatized therapist may find it more difficult to calm and comfort himself and may turn to external sources of comfort, relief, or numbing, such as alcohol consumption, overeating, overspending, overwork, and television. He may find himself craving caretaking from others but unable to ask effectively for what he needs. He may feel overwhelmed with his life outside of work, unable to respond to his loved ones' needs, and unable to set limits or obtain support.

Ego Resources

The particular ego resources that are most sensitive to the effects of vicarious traumatization include: the ability to make self-protective judgments, the ability to be introspective, the ability to establish and maintain boundaries, the ability to take perspective, including empathy and sense of humor, the ability to strive for personal growth, and an awareness of one's psychological needs. Cognitive processing, which is also sensitive to the effects of vicarious traumatization, can become clouded.

A variety of maladaptive or harmful behaviors can ensue when these resources are impaired, including: overwork, decision-making difficulties, a loss of sensitivity to our own needs, a lack of interest in others in our lives, and a truncation of our personal growth. One can easily take on one more client, add another evening hour, pick up another challenging client, agree to write one more paper or chapter or give one more talk or workshop, or assume other responsibilities without considering the impact on oneself and one's personal life. It is not uncommon for therapists new to trauma therapy to become very absorbed in learning more about the work; this curiosity can become an obsessive preoccupation that excludes other interests. When a therapist is less introspective and has less access to his cognitive and perspective-taking abilities, he can become myopic in his therapies. He may focus on content to the exclusion of process, and he may be unable to process his own contributions to conflict in the therapeutic relationship. The loss of empathy with clients poses a profound danger to any therapy and can result in retraumatization of survivor clients.

Psychological Needs

The same five psychological needs that are sensitive to disruption by trauma are susceptible to the effects of vicarious traumatization. Disruptions in these need areas translate into interpersonal difficulties.

Safety

Just as safety appears to be disrupted for most trauma survivors (Pearlman et al., 1992), so too is it the most vulnerable need area in trauma therapists (Pearlman & Mac Ian, 1994). A disrupted sense of safety implies increased fearfulness, a sense of personal vulnerability to harm, and increased fears for our children and other loved ones (Dyregrov & Mitchell, 1992). Therapists often report nightmares that reflect disrupted safety. Behavior changes reported by trauma therapists with safety disruptions* include: talking to themselves self-critically, rejecting their partners' sexual advances, avoiding having people walk behind them, being told by others that they are too self-critical, not trusting their instincts with clients, checking the doors and windows, avoiding crowded streets, and listening for unusual noises.†

A disrupted sense of safety can also translate into hypervigilance and an expectation of victimization. The loss of one's sense of security and safety

*As measured by the TSI Belief Scale, which is in the appendix.

†The behavior change data reported here and in the following sections are behaviors that were significant at the $p < .001$ level among a sample of 188 self-indentified trauma therapists (Pearlman & Mac Ian, 1994).

permeates one's daily life. While women in American society generally live with greater fear than men (Gordon & Riger, 1989), those fears can be heightened by trauma work. Male therapists may be unaccustomed to feeling such constant apprehension and find it leads to identity and world view disruptions.

Trauma therapists are likely to experience a greatly increased sense of vulnerability relative to their children. This can be one of the most painful and evident aspects of vicarious traumatization for therapists who are parents. It is easy to lose perspective on what constitutes excessive risk and to move to an overprotective stance with one's children.

Trust

When trust in oneself is disrupted, the individual feels less able to be independent. He no longer trusts his perceptions of other people, social situations, or his own feelings. He may rely more heavily upon others to meet his needs, no longer trusting himself to meet them.

The loss of trust in one's judgment decreases one's safety in the world. When an individual does not trust his judgment or ability to judge others, he may find himself trusting everyone. Indiscriminate trust can lead anyone into situations of danger. The less access one has to his feelings, the less information he has to assess situations and people and form appropriate judgments.

When our trust in others is disrupted, we, like our clients, may uniformly reject all external resources. Our counterdependent difficulty asking for help can hinder us in many aspects of our lives. We may be mildly suspicious of others' motives, unable to trust as fully as we once did, or anticipate betrayal in all situations. Our lives as intimate partners, as friends, and as parents may become more difficult as we view our loved ones with less innocence and trust than may be warranted.

Trauma therapists with disrupted self-trust schemas reported the following behavior changes: being self-critical, being told they are self-critical, avoiding looking at themselves in the mirror, avoiding having people walking behind them, and not trusting their instincts with clients (Pearlman & Mac Ian, 1994).

Disruptions in other-trust in our therapist sample correlated significantly with dropping out of community affairs, making excuses to avoid social situations, preferring to go to the movies or eat alone, avoiding having people walk behind themselves, feeling ready to leave social functions shortly after arriving, going long periods without seeing friends, waiting for the day's end in order to be alone, shopping to make themselves feel better, avoiding crowded streets, and listening for unusual noises.

Esteem

Disruptions in esteem that develop from vicarious traumatization can lead to a generalized more negative sense of self-esteem. One might question, "If I can't help other people, what good am I?" Our esteem can be affected in relation to ourselves as professionals (as therapists or colleagues), as human beings, as women or men, as friends, and so forth. In our trauma therapist sample (Pearlman & Mac Ian, 1994), those with disrupted self-esteem schemas reported the following behaviors as a result of their trauma work: being self-critical, being told they are too self-critical, avoiding looking at themselves in the mirror, and hurting or harming themselves.

Impairments in esteem for others are a likely outcome of work with survivors of sexual trauma as therapists hear story after story of people who acted selfishly, neglectfully, or cruelly. We may degrade and devalue others, or simply ignore or dismiss their interests, concerns, and needs when they differ from ours. Disruptions in other-esteem schemas in our trauma therapist sample correlated significantly with dropping out of community affairs, avoiding having people walk behind them, shopping to comfort themselves, and listening for unusual noises.

A therapist with disruptions in esteem for others may assume that anyone not working with survivors or on issues of social reform is shallow or ignorant. Alternatively, as a therapist loses respect for himself, he may unrealistically idealize others whom he perceives as stronger, more resilient, or more capable or talented than himself. Loss of self-esteem and of esteem for others both decrease the therapist's connection with self and others.

Intimacy

An awareness of pervasive human cruelty can lead to emotional numbing which, in turn, blocks feelings of intimacy with oneself and with others. Intimacy requires connection with one's innermost feelings and thoughts. When we block pain, we lose touch with other feelings as well. Loss of self-intimacy inhibits enjoyment of one's usual individual pursuits and creativity. In our trauma therapist sample, those with disruptions in self-intimacy reported going out to avoid being alone and avoiding looking at themselves in the mirror (Pearlman & Mac Ian, 1994).

Numbness also inhibits interpersonal (other-) intimacy as we pull back from others to avoid disappointment or loss. Some research has found therapists to be more distant emotionally than others from their families (Farber, 1983b, 1983c; Henry, Sims, & Spray, 1973) and more restricted in the number, range, and intensity of their friendships over the years (Cogan, 1978; Farber, 1983a). Our partners may perceive that our clients

and/or colleagues are more important to us than they are, that others receive our best time, that we are more available to them emotionally and at times physically (when we, for example, as a matter of course interrupt dinner to take a work-related phone call). Therapists can feel caught between an angry partner and an anxious client and solve this dilemma by withdrawing from both of them.

We may move away from colleagues who do different types of work or who do not view our work sympathetically. Therapists working with adult survivors may find it difficult to work or socialize with colleagues who are unaware of the extent and seriousness of childhood sexual abuse, dissociative identity disorder, or organized sadistic abuse. We may find ourselves preoccupied with our work, which in itself distances us from others.

The therapists with disruptions in other-intimacy reported avoiding entering a room full of strangers, staying in bed to avoid seeing anyone, making excuses to avoid social situations, preferring to go to the movies or eat alone, avoiding having people walk behind them, going long periods without seeing friends, and shopping to make themselves feel better.

Control

Through the work of trauma therapy, a therapist can experience a diminished sense of self-control. He may identify with his clients' previous helplessness or become aware that his own life and future are subject to the actions of others in ways he cannot hope to predict or control. These beliefs lead to distress as we question our ability to take charge of our lives, to direct our future, to express our feelings, to act freely in the world.

Trauma therapists may experience disruptions in the realm of other-control, one manifestation of which is an attempt to exercise greater control over others. They may move to taking greater control in their personal relationships in order to compensate for their inability to control the events in their clients' lives. The impossibility of controlling others can then lead to a narrowing of one's world in an attempt to operate largely in a world which can be controlled. There is of course tremendous loss in this solution as well, as traumatized therapists restrict their lives and their opportunities out of fear.

Alternatively, disruptions in other-control can result in a surrender of control in situations where control is appropriate and possible. One can give up any sense of an ability to influence or lead others as one comes to accept the helplessness of clients in their experiences of abuse.*

*We do not have data on the behavior changes in those therapists with disruptions in control schemas.

Sensory System

Through exposure to clients' reported memories, therapists may experience disruptions in their own sensory systems. The possibility that clients' clinical material may activate personally traumatic or painful memories for the therapist (Catherall & Lane, 1992; Marvasti, 1992; Saakvitne, 1992) makes this experience additionally complex (see chapter 8).

Imagery

A hallmark of vicarious traumatization is the intrusion of clients' violent sadistic imagery into the therapist's own inner life. Images that clients report in detailed and vivid language can stay with the therapist long after the therapy hour. For therapists who work with survivors of sexual assault this often means dealing with intrusive, sometimes violent, sexual imagery in the therapist's personal life, and often in his sexual life, a process also noted by Maltz (1992). It is not uncommon for the trauma therapist to find his own sexual experience abruptly interrupted by the unbidden images or bodily sensations that were described by his client. This is a profoundly personal and distressing event, just as similar intrusions in the form of flashbacks can be terrifying for the survivor herself.

The images most likely to stay with, intrude upon, and distress the therapist are those that in some way connect with his salient psychological needs. Thus, for example, a client may relate a particularly vivid memory of abuse which contains a theme of abandonment. For a therapist with central dependency needs, themes of abandonment will be particularly meaningful. Thus the therapist's worst fears may be realized in his client's experience, and that identification will frame his response to the client, sometimes facilitating empathy, other times interfering with it. This image may return to haunt the therapist until he recognizes the central theme and works it through in an appropriate forum (such as supervision, a vicarious traumatization consultation, or his own therapy).

In our study of trauma therapists (Pearlman & Mac Ian, 1994), we found that therapists without a trauma history were more likely to report experiencing intrusive imagery as a result of exposure to clients' trauma material than were therapists with a trauma history. Perhaps therapists with a trauma history have developed ways of coping with traumatic imagery. Dyregrov and Mitchell (1992) have also noted that those working with traumatized children report experiencing intrusive imagery.

Bodily Experiences

It is not uncommon for therapists to experience bodily sensations which parallel those described by their survivor clients. Genital pain, numbing of

various body parts, and strange physical sensations during sessions have all been reported by trauma therapists working with sexual abuse survivors and dissociative individuals. To the extent that these experiences are hidden in a cloak of confusion or shame, they cannot be addressed and resolved. Therapists sometimes carry these experiences out of the therapy office, and many trauma therapists report informally they are much more dissociative in everyday life than they were prior to doing trauma work.

Other Sensory Experiences

Many trauma therapists develop a sensitivity to other sensory experiences, such as certain sounds or smells. After hearing story after story about children being abused in basements, unexpected noises from one's own basement can lead to a startle response or racing heartbeat. The taste or smell of alcohol can become negatively conditioned simply through hearing stories of abusive drunken adults. These responses are more likely in individuals in whom these sensory modalities are more highly developed than the imagery system, which tends to be the most common sensory modality in individuals in our culture.

It is clear that unaddressed vicarious traumatization poses hazards to the therapist and all of his relationships, both personal and professional. As vicarious traumatization affects the self of the therapist, it will emerge in the therapeutic relationship directly and through countertransference. The recognition of vicarious traumatization is an essential first step to self-protection.

Concomitantly, this work provides therapists with unparalleled opportunities for personal and spiritual growth. When aware of the risks, therapists can work to minimize the deleterious effects and maximize the positive transformative effects of their profession on all aspects of their selves.