PRACTICE

VICARIOUS TRAUMATIZATION: THE EMOTIONAL COSTS OF WORKING WITH SURVIVORS

—by Lisa McCann and Laurie Anne Pearlman

Psychotherapy with survivors of child sexual and physical abuse presents a special set of challenges to therapists. Just as trauma strongly affects victims, working with victims and survivors alters therapists' ways of understanding the world and their beliefs about themselves and others, and can create distressing imagery. How can therapists understand and resolve these effects in order to remain open and helpful to their clients?

Our work with trauma survivors over the past years has included psychotherapy with child and adult victims of sexual and physical abuse, as well as victims of accidents, war, and other crimes and traumas. Through our clinical work and study of the literature (McCann, Sakheim, and Abrahamson, 1988), we have developed a theory for understanding these effects. This theory, which we call Constructivist Self Development Theory (CSDT), provides therapists and clients with a framework for understanding and treating trauma survivors (McCann and Pearlman, 1990a; McCann, Pearlman, Sakheim, and Abrahamson, 1988) The theory also applies to therapists who, treating trauma victims, undergo what we call "vicarious traumatization" (McCann and Pearlman, 1990).

Disruptions in identity and frame of reference schemas

A fundamental premise of CSDT is that trauma disrupts victims' sense of identity. Abused children develop ways of understanding who they are and why they are being abused. Children may come to view themselves as defective or worthless—thinking, "I'm abused because I'm bad"—as a way of integrating the abuse with what are likely to be more positive views of their abusive parent. These beliefs about who we are, how we came to be this way, and why things happen to us, are called "frame of reference" schemas in CSDT.

Therapists' identity and frame of reference schemas are very often affected by working with survivors. Therapists may initially picture themselves as effective people who, caring deeply about children, can help them resolve the negative impact of abuse. But over time, therapists learn that their ability to be helpful depends at least as much upon the family, the judicial system, and the social services system as upon their own compassion and skills This fundamental realization can have a profound impact upon the clinician's identity as a helper Furthermore, as helpers struggle to make sense out of an often violent and unpredictable world, they may lose their bedrock faith that the world is just and kind. These changes in therapists' frame of reference schemas about justice, control, and causality are the result of a very painful and difficult process.

Disruptions in central psychological needs and related cognitive schemas

In addition to shaping identity, traumatic experiences shape our assumptions and beliefs about self and others in six central need areas: safety, trust, esteem, independence, power, and intimacy. Everyone has these needs, and our individual life histories determine which of them are most important for each of us. Like victims, therapists will be affected most in the specific need areas which are most important to us.

Trauma therapists for whom safety needs are central may experience an increased sense of personal vulnerability, perhaps to auto accidents or to personal assault. These therapists may report a heightened sense of fear, vulnerability, and hypervigilance as a result of their work.

Other helpers, whose trust needs are high, may become painfully aware of the many cruel and sadistic ways people can betray the trust of others. These helpers may become more suspicious of other peoples' motives and may feel less trusting of other adults, such as babysitters or scout leaders, who come into close contact with children.

The central need to hold others in high esteem is very sensitive to work with victims of crime and abuse. The therapists's fundamental belief that people are good can be severely challenged by hearing time and again about cruelty inflicted upon defenseless children. Therapists may develop a view of humanity that is much more cynical and pessimistic than that with which they entered the field. One trauma therapist said, "I used to believe that people were basically good and did the best they could to raise children; I now believe just the opposite."

Therapists whose need for independence is strong may find it difficult to continue to believe that they can control their own lives in the face of the apparent randomness of traumatic events. These therapists may begin to dream about being confined or trapped, and may start to feel anxious about their own ability to move about at will. A female therapist who treats a client who was raped in the rural area in which they both jog may decide not to jog in her own neighborhood, and feel hemmed in and resentful as a result.

Those with a strong need for power may respond defensively to the apparent assault on that need that trauma represents These therapists may respond by prematurely encouraging victims to confront their abusers, and by gradually shifting from a mature expression of their need for power—leading others—to a less mature expression of that need—controlling others. They may experience despair about their own helplessness in preventing child abuse, a feeling that for them may quickly lead to burnout.

Finally, therapists whose intimacy needs are central may feel increasingly distant from others outside the field. The growing awareness of the magnitude and impact of child abuse can leave the therapist feeling alienated from friends and family who do not share this perspective. People who ask, "How can you listen to such terrible things day after day?" only increase the sense of alienation

Disruptions in imagery

Like trauma survivors, helpers may experience intrusive and disturbing imagery or dreams that relate to the client's traumatic material When clients report graphic visual memories of specific traumatic events which connect with the therapist's salient psychological needs, the therapist may experience unbidden images that parallel these traumatic memories. These images can evoke feelings of sorrow, anger, or repulsion in the helper. Helpers, like trauma survivors, may defend themselves from these feelings through psychic numbing, denial, and distancing. If unresolved, this defensive reaction can lead to detachment and a decreased willingness to probe for traumatic material, and thus to a reduced ability to be helpful.

CSDT posits that therapists often experience disturbances in the imagery that reflects their most profoundly disturbed need areas. That is, helpers who experience intrusive imagery related to threat and harm may be reflecting a greater disturbance in their feelings of safety, while those who focus on the horror of helplessness and subjugation may be experiencing a greater disruption in the area of independence. These images are most disturbing if therapists do not have an opportunity to talk about their feelings in a supportive environment, an issue we address below.

Resolving Vicarious Traumatization

Traditionally, countertransference has been viewed as somewhat shameful, as it reflects the therapist's own unresolved past issues. Many therapists fear being devalued if they acknowledge the impact of trauma work. We contend, however, that most therapists will experience vicarious traumatization, in specific ways that relate to their own personality and history, regardless of whether or not they have unresolved past issues. Just as post-traumatic stress disorder is a normal reaction to an abnormal event, vicarious traumatization is an inevitable result of working with survivors Helpers who have been victims themselves may of course need to work through their own experience in a therapeutic context; but all trauma therapists are likely to need special help

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dealing with the impact of working with victims.

We strongly recommend that all trauma therapists find a way to meet regularly with other trauma therapists, both to discuss difficult case material in ongoing clinical supervision (with client consent, of course), and to share the ways in which this work has affected them. Finding such company may be harder for therapists in private practice, but for them it is all the more important for combating a sense of alienation. If therapists are to minimize the damage of vicarious traumatization, they must find safe and supportive places in which these painful issues can be fully explored and resolved.

Just as survivors must find ways of nurturing themselves, so too must trauma therapists develop ways of restoring themselves. In the work setting, this might mean balancing clinical work with nonclinical work, such as research, consultation, teaching, or writing. It might also mean taking on some non-trauma clinical work or non-direct service work, such as supervision. Attending professional meetings, conferences, and workshops can provide important skills, supportive professional contacts, and restorative breaks from the ordinary.

Therapists must also set appropriate limits with clients, allowing themselves time away from clients for renewal. To keep their work from being a 24-hour per day commitment, therapists may choose to keep their home phone numbers unlisted, and very rarely, if ever, give them out to clients. Therapists may need to negotiate with the agency administration to secure sufficient work time in which to take care of themselves: time for breaks, time for regular meetings with other therapists, time to step back and assess their emotional needs and devise strategies for meeting them. Therapists can also use team meetings to set up triage to balance cases, so therapists are not overloaded with cases they know are particularly difficult for them, and so that, if possible, every therapist has some non-trauma cases.

Using humor with clients, always in a gentle and supportive way, can both provide a useful model for clients and can help the therapist in the continual pursuit of perspective. Using humor doesn't mean telling jokes, but stepping back to look at the bigger picture, and appreciating the irony and absurdity of existence.

Acknowledging and valuing one's contributions to clients' lives, rather than focusing on how little one can do, is essential to continuing to do the very important work of trauma therapy. Many therapists find themselves demoralized by such thoughts as, "This problem is so huge, I can't possibly do anything about it," and "What I do may be good, but it's not nearly enough." Therapists need to focus on the much smaller, more manageable picture of what *they can do*, not what needs to be done. "Look at how much better Betsy's doing," is a more reasonable and helpful thought than, "Look at the size of the problem!" Another helpful thought is that we are just one part of a massive system that is mobilized to help this population. Like everyone else, we are responsible for doing our part well, not for doing the whole job. Weekly, regularly scheduled "Good News" sessions about client progress, positive legislation, and good court decisions, can boost everyone's morale.

Time away from work is also essential. This includes taking time during the day for breaks, lunch, perhaps a brief phone contact with a friend, and taking time off from work on weekends and for vacations.

Outside the work setting, it is important that therapists play and rest. Many therapists feel guilty having fun and love in their lives when their clients, about whom they care so much, are suffering. But the belief, "I shouldn't have fun when others are suffering," is counterproductive. In fact, we can't help others as well if we are not taking good care of ourselves. We do much more for our clients if we allow ourselves self-renewal through love and fun than if we don't.

Stay in touch with friends and family. Pursue individual interests that restore a sense of peace, such as the enjoyment of music or nature. Engage in enjoyable social activities. Finding positive and playful ways of connecting with children, whether through or outside of work, can be restorative after the difficult work of bearing witness to abused children's realities. Modeling our determination to care for ourselves in this way is a gift for each other and for less experienced colleagues.

Finding ways of identifying and articulating the importance and value of one's work to loved ones and colleagues can help diminish the alienation that trauma therapists sometimes experience. When we're asked, "How can you stand it?" the most helpful response is to explain exactly how we *do* stand it. We can explain the impact our work has on us, and what we do to cope. If they understand what we go through, our loved ones and friends are in a better position to support us. We may also be able to say, truthfully, that our work has helped us experience a greater sense of hope; that seeing the tremendous ability of ordinary people to cope with, and even grow through, extraordinary pain has given us a new and profound respect for the resilience and creativity of human beings.

Some therapists find social activism a useful means of transforming the pain related to trauma work into a gift for others. Working for the passage of legislation to protect victims, or working on task forces on primary prevention or women's issues can help therapists feel that they're part of the solution on a large scale as well as on a small one.

In essence, the process of identifying and managing vicarious traumatization is parallel to the therapeutic process with victims: both require continual monitoring and processing. We hope this article provides a framework for conceptualizing vicarious traumatization and encourages helpers to acknowledge and ultimately resolve these painful issues.

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IL	93	ID	14
MA	85	MS	14
NY	72	IN	13
TX	57	NH	13
WA	43	NM	12
OK	40	CT	12
PA	39	DC	12
VA	36	LA	11
GA	33	KS	10
AZ	32	IA	9
FL	30	KY	9
MD	30	AK	7
NJ	29	NE	7
WI	29	RI	7
CO	29	UT	7
MN	27	AR	6
OH	27	SC	4
MI	23	VT	4
MO	22	WY	3
NV	22	DE	2
OR	20	MT	1
AL	18	ND	1
ME	18	WV	1

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