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Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims

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Within the context of their new constructivist self-development theory, the authors discuss therapists' reactions to clients' traumatic material. The phenomenon they term "vicarious traumatization" can be understood as related both to the graphic and painful material trauma clients often present and to the therapist's unique cognitive schemas or beliefs, expectations, and assumptions about self and others. The authors suggest ways that therapists can transform and integrate clients' traumatic material in order to provide the best services to clients, as well as to protect themselves against serious harmful effects.

KEY WORDS: countertransference; post-traumatic stress disorder; contact victimization; trauma; therapy with victims; burnout.

INTRODUCTION

Tom, a married man in his late 20's and father of two young children, was frequently disturbed by intrusive images involving danger befalling his loved ones. He became obsessed with safety precautions and was hypervigilant about strange noises in his house. As a result, he often woke up suddenly in the middle of the night, fearing that a prowler was in the house. Despite the absence of evidence of immediate danger, he would lie vigilant in his bed for several hours before finally dropping off to sleep. These recurrent feelings of impending danger disrupted his sleep pattern and left him with a pervasive sense of anxiety and vulnerability.

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Joan, a single parent and mother of two school-aged daughters, often attended school functions with other parents in the community. During one event, she observed a father stroking the hair of his young daughter, an exceptionally beautiful little girl. Suddenly, she experienced a vivid image of the father forcibly sodomizing the child, an image associated with feelings of disgust and anxiety. She quickly found a friend to talk to and consciously pushed the ugly image out of her mind. She reflected later that she often found herself distrustful of other people's motives, particularly where the potential abuse of children was involved.

Ann, a single woman in her 30's, would awaken in a cold sweat after experiencing a vivid, recurrent nightmare of being raped brutally at knife point. She would turn on all the lights and lie awake until the dawn broke. After these nightmares, she reported feeling vulnerable and exposed. Over the subsequent weeks she experienced intrusive thoughts about knives and became fearful of being around knives.

What do these three people have in common? Are they experiencing the psychological aftereffects of incest, rape, or some other traumatic violation? Indeed, these people are evidencing some of the cardinal signs and symptoms of the aftermath of a serious victimization. The nightmares, fearful thoughts, intrusive images, and suspicion of other people's motives are common among persons who have been victimized. However, neither Tom, Joan, nor Ann has directly experienced a victimization or catastrophe. What they do have in common is that they are all mental health professionals who spend a significant proportion of their professional time doing therapy with or studying persons who have been victimized. Although all of them have advanced degrees and training, including supervision in the treatment of victims, they are not immune to the painful images, thoughts, and feelings associated with exposure to their clients' traumatic memories. These reactions can occur as a short-term reaction to working with particular clients, as described in the literature on countertransference in work with victims (e.g., Blank, 1987; Danieli, 1981; Lindy, 1988) or as a long-term alteration in the therapist's own cognitive schemas, or beliefs, expectations, and assumptions about self and others.

Therapists who work with victims may find their cognitive schemas and imagery system of memory (Paivio, 1986) altered or disrupted by long-term exposure to the traumatic experiences of their victim clients. In this paper, we describe this transformation and provide a new theoretical context for understanding this complex phenomenon. Through the explication of the trauma-related alterations in the therapist's cognitive schemas, we build upon the existing literature to provide a systematic basis for assessing and understanding therapists' unique responses to clients' traumatic material. Our work at The Traumatic Stress Institute, a private mental health or-

ganization devoted to the treatment of trauma survivors, has shaped our thinking about this issue as well as providing the case material presented in this paper.

In the past two decades, mental health professionals have shown an unprecedented interest in the psychological aftermath of victimization (e.g., Figley, 1985, 1988; Horowitz, 1976; Lifton, 1973; van der Kolk, 1987). This interest has extended to a wide variety of victimizing events. While an extensive knowledge base exists on the psychological consequences of traumatic experiences for victims, less attention has focused on the enduring psychological consequences for therapists of exposure to the traumatic experiences of victim clients. 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. We term this process "vicarious traumatization."

First, we review previous conceptualizations of the client's impact on the psychotherapist and the psychotherapeutic process. Next, we apply our constructivist self-development theory to understanding the psychological impact of working with victims. Finally, we discuss the implications of this theory for clinicians who work with trauma victims.

PREVIOUS CONCEPTUALIZATIONS

Burnout

Working with victims clearly has much in common with working with any difficult population, such as seriously ill persons, victims of poverty, or persons with very severe psychiatric or social problems. Burnout refers to the psychological strain of working with difficult populations. From a social learning theory (Rotter, 1954) point of view, burnout might be conceptualized as the state in which one's minimal goals are too high and are not changed in response to feedback.

The symptoms of burnout have been described as depression, cynicism, boredom, loss of compassion, and discouragement (Freudenberger and Robbins, 1979). The research on burnout among therapists suggests the following as contributing factors: professional isolation, the emotional drain of always being empathetic, ambiguous successes (Bermak, 1977); lack of therapeutic success, nonreciprocated giving and attentiveness (Farber and Heifetz, 1982); and failure to live up to one's own (perhaps unrealistic) expectations, leading to feelings of inadequacy or incompetence (Deutsch, 1984). Although the burnout literature has not specifically ad-

dressed the effects of working with victims, these concepts are clearly relevant.

Working with victims may produce symptoms of burnout in mental health professionals for a number of reasons. Victims of undisclosed traumas may present with chronic, entrenched symptoms that are difficult to treat and require long-term therapy. Furthermore, trauma victims may be reluctant to focus on traumatic memories, a source of potential frustration for the therapist. Finally, helpers who understand victimization as a reflection of social and political problems may feel hopeless about the potential impact of individual psychotherapy upon the root causes of crime and violence.

We believe that burnout among therapists who work with victims has special meanings. That is, symptoms of burnout may be the final common pathway of continual exposure to traumatic material that cannot be assimilated or worked through. The symptoms of burnout may be analogous to the trauma survivor's numbing and avoidance patterns in that each reflects an inability to process the traumatic material.

Although the burnout literature is relevant to working with trauma victims, we concur with others (e.g., Danieli, 1981; Haley, 1974) that the potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious traumas.

Countertransference

The countertransference literature provides additional useful background for understanding this complex phenomenon. Countertransference traditionally has referred to the activation of the therapist's unresolved or unconscious conflicts or concerns. Freudenberger and Robbins (1979) write: "(in therapy), the therapist's old scars and injuries are constantly rubbed anew" (p. 287). Similarly, Farber (1985) suggests that the work of psychotherapy may reactivate therapists' early experiences and memories.

Within the victimization literature, countertransference has more broadly incorporated the painful feelings, images, and thoughts that can accompany work with trauma survivors. Haley (1974) originally described the intense and sometimes overwhelming emotions that can be evoked by exposure to images of atrocities or abusive violence reported by Vietnam veterans. In reporting her own reactions to hearing about atrocities experienced by her clients, Haley describes feeling "numbed and frightened" and cautions therapists to confront their own sadistic and retaliatory wishes. Blank (1984) states that persons who work with Vietnam veterans must face the

darkest side of humanity and forever be transformed by it. Scurfield (1985) suggests that work with these clients may stir up ambivalent, negative, or moral/judgmental feelings in the therapist and suggests the importance of confronting one's own feelings of aggression, rage, grief, horror, loss of control, and vulnerability. Margolin (1984) describes therapists' reactions to Vietnam veterans as centering around existential anxiety about death and non-being. Furthermore, Blank (1987) describes cases in which therapists experience an intrusion of their own unresolved traumatic experiences, including unresolved Vietnam experiences. With regard to work with incest survivors, Herman (1981) suggests the danger for female therapists of overidentification with the victim and rage at the perpetrator. In contrast, male therapists may experience overidentification with the aggressor.

The most comprehensive models of countertransference reactions among therapists who work with victims cite the following issues and themes. In her work with therapists who work with Holocaust survivors, Danieli (1981) found empirical validation for some of the following themes: guilt, rage, dread and horror, grief and mourning, shame, inability to contain intense emotions, and utilization of defenses such as numbing, denial, or avoidance. In a similar model, Lindy (1988) identified a number of symptom patterns that emerged in therapists in their work with Vietnam veterans. These included nightmares, intrusive images, reenactments, amnesia, estrangement, alienation, irritability, psychophysiologic reactions, and survivor guilt.

Finally, within the area of victimization, there is evidence that persons close to the victim, such as family members, may suffer signs and symptoms of traumatization similar to those of the victim. This concept has been described by Figley (1983) as secondary victimization. For example, there is evidence that children of Nazi concentration camp survivors (Danieli, 1985; Freyberg, 1980) and Vietnam combat veterans (Kehle and Parsons, 1988) may experience social and psychological difficulties. Critical incident stress, an acute type of post-traumatic stress disorder (PTSD), has also been observed in emergency workers who are at the scene of environmental disasters or accidents involving loss of life (Mitchell, 1985).

Overall, the above writings suggest that exposure to the traumatic experiences of victims may be hazardous to the mental health of people close to the victim, including therapists involved in the victim's healing process. These different literatures parallel the two lines of thinking in the field of traumatic stress which place different emphases on whether characteristics of the stressor or individuals' personal characteristics determine their responses to trauma. That is, the literature on burnout parallels the focus on characteristics of the stressor in that it suggests that the therapist is distressed because of the nature of the external event (isolation, difficult client population, and so forth). On the other hand, the countertransference liter-

ature parallels the focus on preexisting personal characteristics to the extent that it attempts to explain the individual's reponses as a function of his or her previous unresolved psychological conflicts. Constructivist self-development theory is interactive in that it views the therapist's unique responses to client material as shaped by both characteristics of the situation and the therapist's unique psychological needs and cognitive schemas.

In addition, we understand the effects on therapists as pervasive, that is, potentially affecting all realms of the therapist's life; cumulative, in that each client's story can reinforce the therapist's gradually changing schemas; and likely permanent, even if worked through completely. This notion has been written about somewhat more broadly in the past. Jung (1966) originally conceived that an "unconscious infection" may result from working with the mentally ill. English (1976) describes this process as follows: "As the emotional needs and distresses of people in difficulty were presented to me, I not only felt them through a process of empathy, but I also found I tended to absorb them within myself as well" (p. 193). Chessick (1978) also hypothesizes that conditions of depression and despair in one's clients (which he calls "soul sadness") can be contagious. Farber (1985) cites evidence that the client can transfer his or her pathology to the therapist. Finally, in a recent book on the personal impact of doing psychotherapy, Guy (1987) cites research which supports the notion that doing psychotherapy can be dangerous to the psyche of the therapist.

Within the area of victimization, others (Blank, 1987; Danieli, 1981; Lindy, 1988) have described a similar phenomenon, generally using the rubric of countertransference, while also raising questions about the adequacy of that construct to explain the phenomenon. Our notion of vicarious traumatization is somewhat broader than countertransference, as it implies that much of the therapist's cognitive world will be altered by hearing traumatic client material. It is our belief that all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having a significant impact on the therapist's feelings, relationships, and life. Whether these changes are ultimately destructive to the helper and to the therapeutic process depends, in large part, on the extent to which the therapist is able to engage in a parallel process to that of the victim client, the process of integrating and transforming these experiences of horror or violation.

CONSTRUCTIVIST SELF-DEVELOPMENT THEORY

The material we present here expands upon our previous work and provides a new theoretical perspective for understanding and working with therapists' reactions. In previous papers (McCann *et al.*, 1988a,b), we described a new theoretical model for understanding psychological responses to victimization. That work focused on the complex relation among trau-

matic life events, cognitive schemas about self and world, and psychological adaptation. We have elaborated that model into a theory of personality we call constructivist self-development theory, described more fully elsewhere (McCann and Pearlman, 1990b). In this paper, we focus primarily on the portion of the theory that describes psychological needs and cognitive schemas.

The cognitive portion of the theory is built upon a constructivist foundation. The underlying premise is that human beings construct their own personal realities through the development of complex cognitive structures which are used to interpret events (e.g., Epstein, 1989; Mahoney, 1981; Mahoney and Lyddon, 1988). These cognitive structures evolve and become increasingly complex over the life span as individuals interact with their meaningful environment. Piaget (1971) described these cognitive structures as schemas. These schemas or mental frameworks include beliefs, assumptions, and expectations about self and world that enable individuals to make sense of their experience. Some of these basic schemas for experience involve beliefs and assumptions about causality, the trustworthiness of sense data, identity, and self-world relations (Mahoney, 1981).

An extensive review of the literature on adaptation to trauma (McCann *et al.,* 1988b) revealed five fundamental psychological needs: safety, dependency/trust, power, esteem, and intimacy. In later elaborations of our work (McCann and Pearlman, 1990b), we have expanded the needs of interest to include independence and frame of reference.

The cognitive manifestations of psychological needs are schemas. Our major hypothesis is that trauma can disrupt these schemas and that the unique way that trauma is experienced depends in part upon which schemas are central or salient for the individual. In this paper, we assert that working with trauma survivors can also disrupt the therapist's schemas in these areas. The therapist's unique reactions will be determined by the centrality or salience of these schemas to himself or herself. In addition to the focus on schemas, our current work (McCann and Pearlman, 1990a,b) includes more emphasis on the imagery system of memory, as well as ego resources and self-capacities. In this paper, we will focus primarily on changes in cognitive schemas and in the imagery system, both areas particularly relevant to understanding vicarious traumatization.

Cognitive Schemas

Beliefs, expectations, and assumptions about the world are central to many current notions about the effects of victimization. Janoff-Bulman (1985) asserts that victimizing life events challenge three basic assumptions or beliefs about the self and the world: the belief in personal invulnerability; the view of oneself in a positive light; and the belief in a meaningful, orderly world. Similarly, Taylor and Brown (1988) have reviewed the evidence that illusions about self and world are adaptive and enhance self-esteem and

mental health. Epstein (1989) presents four basic assumptions which he asserts are disrupted by trauma. These include the beliefs that the world is benign, the world is meaningful, the self is worthy, and people are trustworthy. The work of Roth and her colleagues (Roth, 1989) draws upon and provides empirical support for Epstein's conceptualization. Our work is consistent with this thinking.

Therapists may experience disruptions in their schemas about self and world when they work with trauma victims. These changes may be subtle or schocking, depending upon the degree of discrepancy between the client's traumatic memories and the therapist's existing schemas. Below, we describe how disruptions in these schemas may be associated with certain emotions or thoughts in the helper.

Dependency/Trust

Through their clients, therapist who work with victims are exposed to the many cruel ways that people deceive, betray, or violate the trust of other human beings, as well as the ways people can undermine those who depend upon them, as is often the case with child victims. This may well disrupt the therapist's schemas about trust. As a result, therapists may become suspicious of other people's motives, more cynical, or distrustful. In the case example of Joan, presented above, we find a helper who works with many incest survivors questioning the motives of parents at her child's school function. In our case conferences about victims, we sometimes observe ourselves expecting the worst from people in our clients' interpersonal worlds. For example, a therapist reporting on a new intake said, "I bet I know how this case is going to come out. The father is probably molesting the daughter, the mother has abandoned her emotionally, and everyone else is looking the other way." Startled by what she had just said, this therapist reflected, "I can't believe I'm saying this. I used to believe that most people are trustworthy and that some people are not. Now I believe just the opposite."

Safety

Images involving a loss of safety, including threats or harm to innocent people, may challenge the therapist's schemas within the area of safety. This will be particularly disruptive if the helper has strong needs for security. The case example of Tom, the therapist who awoke one night with fearful images of being violated by a prowler, involves a therapist who works with many victims of acute traumas, such as crime or rape. In this instance, the therapist strongly identified with his middle class suburban clients who

were victims of a burglary. His own fearful images closely corresponded to the images they reported in therapy. In other instances, the connection between the client's images and the therapist's response is not as readily apparent. For example, the helper might experience increased thoughts and images associated with personal vulnerability, such as loved ones being killed in a car accident. Therapists who work with victims of rape or other crime may experience a greater need to take precautions against such a violation. Overall, clinicians who work with victims of random violence or accidents may experience a heightened sense of vulnerability and an enhanced awareness of the fragility of life.

Power

Persons who have been victimized often find themselves in situations of extreme helplessness, vulnerability, or even paralysis. Exposure to these traumatic situations through the client's memories may evoke concerns about the therapist's own sense of power or efficacy in the world. In our experience, helpers with high needs for power are likely to be greatly impacted by the powerlessness reported by their clients. This can at times lead therapists to urge clients inappropriately to take action rather than to help clients understand the meanings of their responses. It is not uncommon to hear rape counselors report that they are taking self-defense classes, no doubt to increase their own sense of power as well as safety. In addition, therapists whose power needs are threatened may find themselves becoming more dominant in social or work situations. One therapist who works with crime victims states that he often fantasizes about how he would protect his family in the event of a criminal victimization. Sometimes these fantasies are brutal or retaliatory, expressing his need to reaffirm his beliefs in his own personal power. Another therapist spoke of wondering how she would respond if she were raped. Sometimes these thoughts became obsessional, as she would replay various rape scenarios over and over in her mind. To the extent that this leads to constructive self-protective action, whether by client or therapist, it is positive. Yet it can become dysfunctional if it leads to inappropriate attempts to control others or anger about one's inability to do so.

Alternatively, a therapist may express a heightened awareness of the illusory nature of control over capricious or unexpected life events. One therapist expressed this by stating, "I realize now how little control I really have over life or death. All that I have worked for can be destroyed in an instant and nothing I do now can prevent that from happening." In extreme cases, a therapist may find himself or herself experiencing feelings of helplessness, depression, or despair about the uncontrollable forces of nature or human violence.

Independence

Trauma survivors, such as victims of rape or other crime, often experience a disruption in their need for independence, such as restriction in their freedom of movement and a diminishment in personal autonomy. One of the therapists in our setting works with many rape and other crime victims. Several of her clients are women with high needs for independence who have experienced a profound diminishment in personal freedom since the victimization. One survivor continues to be terrorized by her assailant, resulting in her decision to move back into her family's home, an event that profoundly disrupted her independence. Her therapist found herself identifying with her client's loss of independence and described experiencing dreams in which she was similarly trapped and confined. While discussing these clients in a case conference, she reflected on how painful it would be "to lose my sense of personal control and freedom in my life" while another therapist, for whom safety was a more salient issue, focused on the sense of personal vulnerability this case elicited in her. For the therapist with strong needs for independence, the identification with clients who have lost a sense of personal control and freedom can be especially painful.

Esteem

We use esteem to refer to the need to perceive others as benevolent and worthy of respect. Persons who are violated or harmed through the uncaring, cruel, or malicious intentions and acts of other human beings may experience diminished esteem for other people or the human race in general.

The helper may also find his or her own view of human nature becoming more cynical or pessimistic. A therapist who had previously held an idealistic view of human nature, reflecting her training in humanistic psychology, experienced a painful shattering of her belief systems after working at the Institute for a year. In case conferences, she would often comment "I can't believe that people treat each other like this" and describe how distressing it was to encounter so much human cruelty. The discrepancy between her own positive schemas about human beings and the reality of the terrible abuses people perpetrate made this a particularly salient and painful issue for her. This diminished view of humanity may be associated with feelings of bitterness, cynicism, or pessimism. Therapists may experience a sense of anger at other people and the world in general as they reflect on the potential malevolence of others. This is a very painful experience as it involves a loss of youthful idealism. On an existential level, therapists may find themselves reflecting on the problem of human perversity and pondering the fate of the human race.

Intimacy

Trauma victims often experience a profound sense of alienation from other people and from the world in general. This experience is most often described in Vietnam veterans who found themselves at odds with a world to which they no longer feel connected (Lifton, 1973). Therapists who work with victims may experience a sense of alienation that results from exposure to horrific imagery and cruel realities. This alienation may be reinforced by other professionals who view the work they are doing with disdain or repulsion. Too often, therapists are asked "How can you listen to such terrible things day after day?" We met a rape crisis counselor at a professional meeting; when asked what kind of work she did, she paused briefly, told us, then pulled in her breath and pulled back slightly, as if waiting for a shocked response. Indeed, she eventually explained with some relief, that was the type of response she ordinarily received. Just as the victim often feels stigmatized (Bard and Sangrey, 1985), so too may the therapist exposed to these horrors experience an uncomfortable sense of separateness from family, friends, or coworkers. This sense of separateness is compounded by the requirement for confidentiality in psychotherapy, which precludes one's ability to reveal the disturbing traumatic material. This of course stands in the way of a sense of connection with others, and, unchecked, may grow into a deep sense of alienation. Finally, other professionals may assume that the therapist chose this particular field of study because of his or her own unresolved conflicts. This too can contribute to a sense that one is stigmatized because of one's association with the field of traumatic stress.

Frame of Reference

The need to develop a meaningful frame of reference for experience is a fundamental human need (Epstein, 1989; Fromm, 1955; Lecky, 1945; Rogers, 1951; Snygg and Combs, 1949). This need is represented cognitively in part in schemas related to causality, or individuals' attributions about why events occur. Traumatized individuals often reflect repeatedly upon the question, "Why did this happen to me?" Similarly, therapists may try to understand why an individual experienced a traumatic event. This can become destructive if it takes the form of victim-blaming. For example, a client reported that her previous therapist of several years minimized the importance of her incest experience, focusing instead on why she had allowed the incest to continue into young adulthood. Therapists can commit another serious therapeutic error by focusing on the possible motives of the assailant or perpetrator. A woman whose former boyfriend tried to murder her reported that her therapist asked her many more questions about the boy-

friend, his family, and his history, than about herself. This seems to reflect the therapist's rather than the client's need to assign causality. The client interpreted the therapist's behavior as the latter's unwillingness to hear her pain, and terminated therapy prematurely.

Another, perhaps more subtle, alteration in frame of reference schemas can also be quite distressing. If therapists' schemas are continuously challenged by clients' reports of traumatic experiences, they can experience an overall sense of disorientation. Without the opportunity to process their experiences, therapists, like clients, can respond to this with a pervasive and unsettling sense of uneasiness.

The Memory System

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. The following sections describe how the therapist's memory system may be affected by exposure to the traumatic memories of clients. These alterations in memory may become intrusive or disruptive to the helper's psychological and interpersonal functioning.

Disruptions in Imagery

The imagery system of memory (Paivio, 1986) is most likely to be altered in vicarious traumatization. Like the trauma victim, therapists may experience their clients' traumatic imagery returning as fragments, without context or meaning. These fragments may take the form of flashbacks, dreams, or intrusive thoughts (Horowitz, 1976) and constitute what some believe to be the hallmark of PTSD (Brett and Ostroff, 1985). These images may be triggered by previously neutral stimuli that have become associated with the clients' traumatic memories. In the case of Ann, presented earlier, the therapist experienced a nightmare that replicated the rape of one of her clients. Another clinician reported the uncanny experience of having a "flashback" that replicated that of one of her clients. This therapist, who works with many Vietnam veterans, found herself staring at a young Vietnamese waitress while ordering food in a restaurant. She described the following experience: "I found myself experiencing a vivid image of hiding in a rice paddy, watching for the enemy. Suddenly, a young Vietnamese girl spotted me and I knew, with horror, that I would have to kill her." The therapist recalls experiencing this as her own memory because the image was so vivid and powerful. These examples suggest that the client's memories may

become incorporated into the memory system of the therapist. The images can then be triggered by what previously was a neutral stimulus.

We also believe that the imagery that is most painful to therapists often centers around the schemas related to the therapist's salient need areas. That is, a therapist for whom safety is salient will likely recall those images that are associated with threat and personal vulnerability, while another, for whom esteem is more central, may focus in on images involving extreme degradation or cruelty at the hands of others. Likewise, the imagery that is recollected can produce a temporary state of disequilibrium as the schemas accommodate or change. Thus, what is recollected in the imagery system of memory is colored by schemas, which are encoded in the verbal representation system of memory (Paivio, 1986). Likewise, the memories (both imagery and verbal components) produce changes in the schemas as the latter accommodate to new realities.

Disruption in the imagery system of memory is often associated with powerful affective states (Bower, 1981; Paivio, 1986). Therapists may report a variety of uncomfortable emotions resulting from their work with victims, including sadness, anxiety, or anger. These feeling states may be activated and within conscious awareness or they may be repressed and out of conscious awareness. Some therapists, particularly those who are unable to process their emotional reactions, may experience denial or emotional numbing. These latter reactions may occur when therapists are exposed to traumatic imagery that is too overwhelming, emotionally or cognitively, to integrate. These feelings may be too overwhelming because the therapist's own capacities for affect regulation or self-soothing are overtaxed or because the traumatic experiences are too discrepant with the therapist's own meaning systems or schemas.

In brief, therapists may experience alterations in their own imagery system of memory through their work with traumatized clients in which they reexperience or avoid various components of their client's traumatic memories. For the most part, alterations in one's memory system are probably transient in nature. However, we believe that these traumatic memories can become permanently incorporated into the therapist's memory system. This is likely to occur when the material is particularly salient to the therapist, relating closely to his or her psychological needs and life experience, and when the therapist does not have the opportunity to talk about his or her experiences of the traumatic material.

SUMMARY

In the previous sections, we provided a theoretical conceptualization of the profound psychological impact of working with trauma victims,

which we refer to as vicarious traumatization. Elsewhere we apply constructivist self-development theory to the conceptualization of unique human beings who experience trauma (McCann and Pearlman, 1990b). Just as trauma alters its victims, therapists who work with victims may find themselves permanently altered by the experience. The unique effects on therapists can be more fully understood within this theoretical framework.

The Transformation of Vicarious Traumatization

In *Civilization and Its Discontents*, Freud (1961) expresses a dim view of human nature that reflects the painful awareness of the cruelty of the world and human beings:

> ...(people) are not gentle creatures who want to be loved, and who at most can defend themselves if they are attacked; they are, on the contrary, creatures among whose instinctual endowments is to be reckoned a powerful share of aggressiveness. As a result, their neighbor is for them not only a potential helper or sexual object, but also someone who tempts them to satisfy their aggressiveness on him, to exploit his capacity to work without compensation, to use him sexually without his consent, to seize his possessions, to humiliate him, to cause him pain, to torture and to kill him. *Homo homini lupus.* (Man is a wolf to man) (p. 58).

Is it inevitable that helpers who work with victims adopt this grim view of Freud's, a view that is both realistic and despairing? Is it possible to have a more optimistic view of humanity than Freud, without denying the harsh reality of violence and aggression? How can the helper be aware of and ameliorate these potential harmful effects, transforming images of horror and violence through his or her own healing process?

Therapists may experience painful images and emotions associated with their clients' traumatic memories and may, over time, incorporate these memories into their own memory systems. As a result, therapists may find themselves experiencing PTSD symptoms, including intrusive thoughts or images and painful emotional reactions. The helper must be able to acknowledge, express, and work through these painful experiences in a supportive environment. This process is essential if therapists are to prevent or ameliorate some of the potentially damaging effects of their work. If these feelings are not openly acknowledged and resolved, there is the risk that the helper may begin to feel numb or emotionally distant, thus unable to maintain a warm, empathetic, and responsive stance with clients.

Helpers must understand how their own schemas are disrupted or altered through the course of this work and also shape they way they respond to clients. Our theory can be helpful in identifying the areas within the therapist where disturbances might exist. For example, therapists for whom safety schemas are salient or disturbed may find it very anxiety-provoking to work with crime, rape, or accident victims. This work can challenge their

own beliefs in personal safety, resulting in a tuning out or avoidance of the client's memories. It is thus important for the helper to assess which of the seven need areas are particularly salient for him or her. This is important because the therapist's reactions to trauma survivors will be shaped by his or her own schemas.

It is important to tap into potential sources of support in one's professional network. The helper should first avoid professional isolation by having contact with other professionals who work with victims. These contacts can provide opportunities for emotional support for one's work in addition to the professional and intellectual support they offer. Professionals within a geographical area might organize support groups for helpers who work with victims. These support groups can be facilitated by experienced professionals who are sensitive to the personal effects of working with victims. Such groups can be focused around three major issues: normalizing the reactions helpers experience in the course of this work; applying constructivist self-development theory to understanding one's specific reactions; and providing a safe environment where helpers feel free to share and work through reactions that are painful or disruptive.

In our two-hour weekly case conference, we spend the first hour discussing and conceptualizing difficult victim cases (with client consent). In the second hour, we move into more personal discussions about what this means to us and how each of us responds to the painful experiences of victims. We refer to this as "feelings" time. As we have grown to trust each other and to allow ourselves to be vulnerable with one another, we have found this time together powerful and meaningful. At times, we have had to process not only our own individual reactions, but also the way in which particularly traumatic cases can affect the entire organization. At times, we struggle with two competing needs: the need to verbalize the traumatic imagery we are attempting to work through and the need to protect our colleagues from the stress of assimilating new traumatic material. The way we have attempted to resolve this is to talk openly about this dilemma and attempt to find a balance between the two needs. At times, we have had to tell each other that we cannot handle hearing details of a particular case because our own personal resources are at a low ebb or because we have particular difficulty assimilating certain types of traumatic material, such as serious violence against children. Fortunately, because the group is large enough, there is usually at least one other clinician who can listen and talk about any particular case. Providing a safe, supportive context for processing these issues is clearly essential to making this format positive and productive.

To this end, it is important that the group members avoid pathologizing the responses of helpers. Just as PTSD is viewed as a normal reaction to an abnormal event, we view vicarious traumatization as a normal reaction to the stressful and sometimes traumatizing work with victims.

While there is no doubt that countertransference reactions that arise from the therapist's own psychic conflicts are also important, we do not presume that the therapist's own unresolved issues always underlie these reactions. On the other hand, therapists' own unresolved victimizations of early childhood experiences can contribute to the process of vicarious traumatization. These reactions should not be viewed necessarily as a sign of psychopathology, but rather as an area of potential growth for the helper. Over the course of this personal exploration, the helper may conclude that he or she needs to work through these more personal issues in his or her own therapy.

Finally, the theory states that individuals will experience and construe events according to their own needs and schemas. As therapists learn more about their own psychological needs, they will be able to process traumatic material more effectively and limit its impact upon their schemas.

In essence, the process of working through vicarious traumatization is parallel to the therapeutic process with victims. We do not offer a quick fix approach to psychological issues that will require continual awareness, monitoring, and processing for those who work with many victims. As the authors were finishing the final touches on this manuscript in an office at home, workers were in the house installing a burglar alarm system. We reflected on the irony of writing an article on this topic while this was happening, as the need for the alarm system was a direct result of disruptions in safety schemas in our work with many crime victims. That our lives have changed in permanent ways must be acknowledged, along with the inherent losses and pain associated with this process.

We have found it useful to share with each other coping strategies that help us ameliorate some of the potential hazards of this work. The coping strategies that have emerged from our weekly discussions include: striving for balance between our personal and professional lives; balancing a clinical caseload with other professional involvements such as research and teaching that can replenish us; balancing victim with nonvictim cases; being aware of and respecting our own personal boundaries, such as limiting evening or weekend work; developing realistic expectations of ourselves in doing this type of work; giving ourselves permission to experience fully any emotional reactions of which we are aware; finding ways to nurture and support ourselves; engaging in political work for social change; and seeking out nonvictim-related activities that provide hope and optimism. Furthermore, it has been important for us to be aware of our conflict areas or unresolved traumas that are reactivated by the therapeutic process.

In a recent article on how mental health professionals cope with working with difficult cases, Medeiros and Prochaska (1988) found evidence that the coping strategy "optimistic perseverance" is adaptive. We concur that maintaining optimism and hopefulness in the face of tragedy is an essential

component to making our work with victims possible. To this end, we also try to acknowledge and confirm the many positive experiences in our work as well as the positive impacts this has had on ourselves and our lives. It is important to remind ourselves and others that this work has enriched our lives in countless ways. In our case conferences, we also share the many personal rewards that are inherent in this work. There is 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.

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