

GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA

MODULE 7: COUNTERTRANSFERENCE: EFFECTS ON THE GROUP THERAPIST WORKING WITH TRAUMA

By

Suzanne B. Phillips, Psy.D., CGP

ABOUT THE AUTHOR

SUZANNE B. PHILLIPS, Psy.D., CGP, is a licensed psychologist as well as a certified psychoanalyst and certified group psychotherapist. She is an Adjunct Professor of Clinical Psychology in the Doctoral Program of Long Island University, at the C W Post Campus, Brookville, New York and is Faculty in the Group Postdoctoral Program of the Derner Institute of Adelphi University, Garden City, New York. She has given on-line panels and training workshops on trauma and has worked with survivor groups, bereavement groups, couple and spouse groups of Uniformed Service Personnel. She is in private practice in Northport, New York.

I. RATIONALE

Against the backdrop of 9/11, this module addresses the risks of those who must enter hazardous terrain to respond to the needs of others. Whether you are a group therapist who has been working with victims of the 9/11 catastrophe, a seasoned therapist who has spent years working with victims of crime, natural disasters, or domestic violence, or a therapist who has been up close to those with a history of childhood sexual abuse, you know that you cannot treat victims of trauma without feeling its impact. Trauma work involves a deliberate use of self as an instrument of healing. Accordingly your countertransference—your living response to the patient’s emotional state at any given moment, your empathic attunement to the victim’s experience of trauma and its sequelae—is your greatest asset and your greatest liability.

While we recognize the personal choice and satisfaction that comes from the privilege of containing and responding to the trauma of others, we know that trauma work is specialized work that is not without personal hazard. The rationale for this module is to protect therapists, clients, and those in the care-taking professions by imparting an understanding of the impact of trauma work and offering an opportunity to support care-takers by recognizing and addressing the effects upon them and their work.

II. OBJECTIVES

- A. To understand countertransference in the group leader working with trauma from a totalistic/interactive perspective.
- B. To provide a working model for the assessment of the group leader’s countertransference in terms of manifestation, source, function, impact and use.
- C. To learn appropriate decision making regarding disclosure of countertransference by a consideration of criteria to be used for determining suitability.
- D. To differentiate countertransference for vicarious traumatization, secondary traumatic stress disorder, burnout and compassion fatigue.
- E. To recognize signs and manifestation of vicarious traumatization.
- F. To identify guidelines of self-care for ameliorating vicarious traumatization.

III. FORMAT OF THE MODULE

- A. Introduction and Rationale
- B. Understanding Trauma and Recovery
 - 1. Diagnostic Criteria
 - 2. Judith Herman (1992) Theory of Trauma and Recovery
- C. Rationale for Use of Group Intervention for Trauma

- D. Understanding Countertransference
 - 1. Definitions of countertransference
 - a. Historical
 - b. A totalistic/interactive definition of countertransference
 - 2. Countertransference of the group therapist
 - a. Types of countertransference
 - i. Historical/subjective
 - ii. Objective
 - b. Complexity of countertransference in groups
 - c. Impact of theory and styles of leadership
 - d. Impact of co-leadership
- E. Characteristics of Trauma Groups that Affect the Leader's Countertransference
 - 1. General differences between trauma groups and on-going psychodynamic groups
 - 2. Specific differences between trauma groups and on-going psychodynamic groups
 - a. Circumstances for meeting
 - b. Goals
 - c. Role of leader
 - d. Members
 - e. Trauma as content
 - f. Anger in trauma groups
 - g. Necessary defense versus resistance
 - h. Dissociation as extreme protection

- i. Definition of dissociation
 - ii. Response to dissociation in a trauma group
- F. Common Countertransference Responses for Leaders of Trauma Groups
- G. Assessment of Countertransference
- H. Disclosure of Countertransference
- I. Understanding Vicarious Traumatization: The Risks of Caring
 - 1. Definition of vicarious traumatization
 - 2. Comparison with secondary traumatic stress, secondary traumatic stress disorder and compassion fatigue
 - 3. Comparison with countertransference
- J. Signs and Manifestations of Vicarious Traumatization
 - 1. Cluster symptoms
 - 2. Pervasive changes
- K. Professional Factors Contributing to Vicarious Traumatization
- L. Ameliorating Vicarious Traumatization
- M. Conclusion
- N. References

IV. UNDERSTANDING TRAUMA AND RECOVERY

Understanding trauma is necessary and important for the group therapist leading a trauma group. Theory can serve as a means to normalize and contain anxiety about what is observed and what can be expected on the road to recovery.

- A. Diagnostic Criteria: The DM-IV-TR considers the following criteria as essential to a diagnosis of Posttraumatic Stress Disorder (309.81) (*Diagnostic Criteria from Diagnostic and Statistical Manual of Mental Disorders, TR, Fourth Edition, 2000, p. 467-468*)

1. The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experiences of an event that involves actual or threat of death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.
2. The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior).
3. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent experiencing of the traumatic event.
4. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.
5. Persistent symptoms of increased arousal.
6. The full symptom picture must be present for more than one month.

B. Theory of Trauma and Recovery

Trauma renders people helpless, overwhelming ordinary systems of care that allow them to have a sense of control, connection, and meaning. When the overwhelming force is that of other human beings the trauma is especially damaging as compared with when the force is found in nature.

1. The Three Symptom Clusters: Herman (1992), in her seminal work on *Trauma and Recovery*, considers that a person's response to trauma is usually manifested in three symptom clusters. These symptoms reflect the fact that each component of the ordinary response to danger, having lost its utility, persists in an altered and exaggerated state long after the actual danger is over.
 - a. Hyperarousal: "The persistent expectation of danger." There is an inability to sleep, relax, eat; emotional lability (the person is easily upset, frightened or angered); intolerance for the stimulation of people, crowds, television; panic and anxiety attacks, dissociative symptoms.
 - b. Re-experiencing: "The indelible imprint of the traumatic moment." There are intrusive images, thoughts, memories, nightmares, and flashbacks.
 - c. Constriction: "The numbing response of surrender." There is little or no affect, the person can't feel, can't cry, and can't remember. There is an avoidance

of anything associated with the trauma or anything emotional or upsetting; an avoidance of social connections, places and things of former interest; an overall disinterest in life's events or in the future.

2. Three-stage process of healing and recovery: According to Herman (1992), the core experiences of psychological trauma are disempowerment and disconnection from others. As such, recovery from trauma is based on empowerment and the creation of new connections with self, the other, one's belief system and the world. Herman offers a three-stage process of healing and recovery. Using this as a basis, a group leader or therapist dealing with trauma would consider recovery in terms of the following:

a. Establishing Safety: Restoration of physical safety by attention to physical healing, sleeping, eating and environmental needs. Normalizing Posttraumatic Stress Disorder (PTSD) symptoms, establishment of trusted places and people, management of exposure and distance from the trauma. (In group, safety is developed by the presence of leader, empathic attunement, established frame, symptom management, pacing, containment).

b. Remembering and Mourning: Involves the retrieval, reconstruction and transformation of traumatic memories by sharing them in a protective relationship. All trauma involves loss. The unanticipated death of a loved one involves assault and then loss. Grieving is a unique process of slowly transforming loss by connection and permission to remembering.

c. Reconnecting: Involves the movement from isolation and helplessness to connection with life, self, others by use of therapeutic relationships, support networks, coping skills, qualities of resilience such as creativity, intelligence, sense of humor, spirituality, new meanings in life- sometimes a survival mission.

V. RATIONALE FOR USE OF GROUP INTERVENTION FOR TRAUMA

A. There has been considerable recognition of the viability of group intervention in addressing trauma (Klein & Schermer, 2000; Johnson & Lubin, 2000; Foy, Eriksson, & Trice, 2001). Support groups, psycho-dynamic groups cognitive- behavioral groups, bereavement groups—all address different aspects of the panic, distrust, disconnection, helplessness, terror, isolation and loss that result from trauma. According to Foy, et al., (2001) group interventions are effective in addressing PTSD and syndromes of trauma because they share key features that “build a therapeutic, safe, and respectful environment” (p.246).

B. Features of Group That Make It Effective

1. Homogeneity of group membership determined by shared type of trauma (combat veterans, adult survivors of child abuse etc.).
2. Disclosure and validation of the traumatic experience

3. Normalization of trauma-related responses
4. Validation of behaviors required for survival during the time of the trauma

VI. UNDERSTANDING COUNTERTRANSFERENCE

A. Definitions of Countertransference

1. Historical perspective

a. Freud (1910) originally considered countertransference to be the therapist's unconscious reaction to the patient's transference and was viewed as a hindrance, something to be analyzed away.

b. Evolved psychoanalytic understanding as a result of the contributions of analysts such as Heiman (1950), Racker (1968) and Kernberg (1965) reconsidered countertransference as a natural and normal development. In their totalistic view, countertransference includes all the therapist's responses (pathological or appropriate) as a source of significant understanding of the patient in the on-going process.

c. Racker's differentiation of countertransference into concordant (identification with the patient's ego) and complementary (identification with some split off part of the patient) furthered the therapist's understanding and use of countertransference. It was Racker who recommended that the analyst first develop an understanding of the patient's internal process in the here and now and then use the countertransference in formulating appropriate reactions.

2. A totalistic/interactive definition of countertransference

a. This module defines countertransference from a totalistic/interactive perspective. It considers the countertransference of the therapist to include his/her conscious and unconscious response and feelings, as well as the verbal and nonverbal reaction to and interactions with the patient based on the therapist's theoretical perspective, training, experience, person (age, gender, marital status, race), personality, history, current life events, psychological and physical needs.

b. According to Roth (1990), the interactive aspect adds to this the intersubjective context created by the interaction of the therapist's total countertransference and that of the total transference (parallel factors) in the patient.

B. Countertransference in Groups

1. Types of Countertransference (Ormont, 1980)
 - a. Historical/subjective
 - i. Repetitive countertransference is one wherein the leader unwittingly repeats or enacts his/her own life issues.
 - ii. Reparative countertransference is when the group therapist not only experiences a replay of his/her own past, but attempts to repair the damage done in his/her own past.
 - b. Objective
 - i. Matched countertransference is where the group therapist feels the same feelings as the group or individual members. The leader is mirroring the group (similar to Racker's concordant countertransference).
 - ii. Complementary countertransference is where the leader feels and takes on those roles that the group or individual members cast upon him/her.

 2. Complexity of countertransference in groups: When considering countertransference in groups, the operational field the group leader is facing is far more complex than that found in individual work. Several countertransferences must be monitored:
 - a. Individual
 - b. Group-as-a-whole

 3. The impact of theory and styles of leadership: Counter-transference in groups is also a function of the therapist's theory of technique and style of leadership (Roth, 1990). Saakvitne & Pearlman (1995) note that theories shape what a therapist (group leader) perceives such that theory inevitably shapes countertransference (p. 96).
 - a. The leader's theoretical orientation affects the countertransference. If the leader adheres to a stage theory of mourning, for example, he/she might impose verbal or nonverbal expectations on the group or individual members for not moving on or letting go as expected. If a leader is comfortable with the use of unconscious material, he/she may be more likely to encourage and use reported dreams as the conscious and unconscious context of the group.
 - b. Personal style also impacts the countertransference. Depending on the leader's assessment of disclosure, i.e. related to being an introvert or an extrovert, he/she may feel comfortable sharing a reaction with the group or feel terribly guilty.
-

4. The impact of co-leadership
 - a. Consonance of theoretical styles is an important component when there are co-leaders. To some degree this is only one aspect of the leader-leader dynamics that occurs in concert with the leaders' countertransference response to the group as a whole, and individual members in the group.
 - b. Pearlman & Saakvitne (1995) consider three stages in co-leadership.
 - i. An initial stage involving issues of self-esteem, shame and self-consciousness
 - ii. A second stage of increased intimacy and communication skills between leaders
 - iii. A third stage reflecting the development of co-parenting and negotiation skills.
 - c. Co-leadership is valuable in trauma groups because it allows for shared containment, de-briefing of difficult feelings and content, affirmation of each other's work and feedback on each other's countertransference.

VII. CHARACTERISTICS OF TRAUMA GROUPS THAT AFFECT THE LEADER'S COUNTERTRANSFERENCE

- A. General Differences Between Trauma Groups and On-Going Psychodynamic Groups
 1. Trauma groups do not follow the schema of developmental stages that we have come to observe in other-on-going groups but have a wide range of developmental possibilities.
 2. While countertransference is important in ongoing psychotherapy groups, it is usually more complex and painful in trauma groups. Ziegler & McEvoy (2000) consider that the hazardous and complex terrain of trauma survivor groups require a therapist to identify, understand and manage complex dynamics. The leader must monitor his/her response to the traumatic material and the responses of group members as well as his/her responses to the group as a whole, the group dynamics and the co-leader. The leader's responses are not negative or positive but rather windows of opportunity for insight and compassion into self and others' past and present realities (p.117).
- B. Specific Differences Between Trauma Groups and On-Going Psychodynamic Groups, especially in the face of a mass trauma:
 1. Circumstances for meeting

- a. Trauma groups often form in the aftermath of catastrophe and disaster. Psychotherapy groups meet when the therapist decides to create a group.
- b. There is little preparation of group members for the group experience. Much time is spent on member preparation in general groups.
- c. There are no implicit and explicit group norms that an existing group maintains and shares with new members. The general group bequeaths norms from generation to generation of new members over time.
- d. Often the leader is new to all members and members may know each other. In general groups the leader knows everyone and usually no one knows another member.
- e. While survivor groups (childhood abuse or incest) have many of the same qualities and similar effects upon the leaders as trauma groups following a mass disaster, they differ in the possibility of preparation of members, as well as the presence of members at different stages of awareness and recovery.

2. Goals

- a. On going psychodynamic groups work toward recognizing, addressing and warding off the characterological patterns that have impaired interpersonal functioning, ego mastery and intimacy
- b. Trauma groups work to restore a sense of stability, security, ego capacity, and reconnection with others and with the future.

3. Role of leader

- a. In the aftermath of catastrophe, the leader of the trauma group has the immediate goal of responding to or stemming PTSD by establishing safety through the creation of a holding environment (Winnicott, 1965), normalization of symptoms, the containment of affect, vigilance to evidence of physical or psychological decompensation, empathic attunement, active listening, visual monitoring of the verbal and non-verbal responses of members, and balancing invitations to share as well as permission to just observe.

The leader (with an understanding of the debilitating nature of trauma and grief) takes a directive initial role in the organization and frame of the group. A silent unstructured response or too rigid or demanding a response by the leader would be inappropriate in establishing a safe environment for a trauma group.

b. The leader of a general psychotherapy group is customarily less active and directive. Maintaining an experience-near stance is not as necessary.

4. Members

a. Trauma groups are often made up of members who share certain aspects of the same trauma or even the same trauma. Cohesion is instantaneous and strong. Members may be reluctant to leave, fearing the loss of the bond with the group and its mutual experience as well as lack of acceptance from those without the same history.

b. While respecting an individual's timeline, a leader must consider when to underscore differentiation as well as historical perspective, self-introspection and renewed mastery in a homogenous group. In this situation the trauma group can be conceptualized as the cornerstone of an internalized structure facilitating the first step in reconnection with the outside world.

c. In general therapy groups the leader must work to create and support cohesion. Leaving the group and moving to the outside world is not complicated by loss of the strong bond inherent in a mutual experience of a trauma.

5. Trauma as content

a. Trauma groups (in the aftermath of sudden onset trauma like 9/11) utilize the venue to tell and re-tell the traumatic events. The leader needs to be alert to "flooding" or re-traumatization of the group by the outpouring of nightmares, graphic memories, etc. It is instructive to note that often a trauma group handles such sharing better than the leader expects because the commonality of the shared trauma serves as the container. Although the leader monitors verbal and non-verbal responses to shared graphic content (slowing the pace by questioning the feelings of the person sharing or the group members listening), members often want to hear about the trauma. It actually serves in the transformation of traumatic, affect-laden memories to narrative memories that can then be integrated. Often it is the leader who is more traumatized by having no context for the "shared details" than the other group members. When the leader is a victim of the same catastrophe his/her response may vary. The shared experience may foster attunement and empathy for group members, or the leader's own assaulted self and post-traumatic responses may leave him/her feeling compromised in the capacity to contain and respond therapeutically.

b. In the general group therapist(s) seldom need to monitor the possibility of re-traumatization: rather the flow of material can be allowed to develop relatively undisturbed by therapist intervention.

6. Anger in trauma groups

a. Whether someone has struggled a lifetime with the characterological scars of childhood abuse or suffered the collapse of self in the aftermath of adult onset trauma, anger is endemic to their suffering. Furthermore the anger can be extremely intense. A number of considerations should be kept in mind:

i. The group leader of a trauma group must face, contain, regulate and respond to the anger in individual members, in the group as a whole as well as in self.

ii. To fail to effectively address masked or overt anger by extremes of avoidance or retaliation is to further the trauma.

-- It sends the message that anger is too dangerous, can never be regulated and is incompatible in close and safe relationships.

-- It impedes recovery because recovery means integration of affect attached to the "imprint" of trauma.

iii. Herman (1992) describes the traumatic transference to the therapist or group leader of those who have suffered abuse. She suggests that their emotional responses to any person have often been "deformed by the experience of terror." (p. 136) and observes that "a destructive force appears to intrude repeatedly into the relationship between therapist and patient" which can be recognized as the violence of the perpetrator. (p. 136) Accordingly there is an expectation of betrayal, victimization and abuse from the leader, as well as certain group members. This manifests in different ways:

-- Overt hostility to the leader, group or members

-- Scrutiny of every word and response to discern the anticipated attack

-- Masked hostility as sarcasm

-- Indifference

-- Joking

-- Idealization and deference to leader, group or members as a way to protect self.

iv. Buchele (1995) states that "being the target of anger from the entire group or by one member as the group watches can be intense and very difficult for the therapist." (p. 282) Using a theoretical model to understand the source of the group or individual member's anger is often helpful to the leader's sense of stability and ability to contain and regulate affect.

-- Livingston & Livingston (1998) suggest that from a self-psychology perspective, anger is a manifestation of the underlying vulnerability of self. It often masks the shame and humiliation, which follow in the wake of trauma.

-- From an object relations perspective, one might understand that the person who has been abused knows only too well the role of perpetrator as there is an internalized dyad of victim/abuser glued together by anger. Given the patient's projection of split-off aspects of self or other, the leader might find himself/herself accused of, identifying with, even acting out the part of the angry perpetrator. On the other hand, the leader may feel victimized by an angry group or a relentless group member.

v. The value of understanding the source of the countertransference is that it informs and expands the leader's understanding of self and the response to the other.

b. In general group's anger is often less intense and less frequent; therefore it is easier to contain and the therapist may feel less tempted to avoid working with it.

7. Necessary defense versus resistance

a. Trauma groups need conscious and unconscious protection. The avoidance or denial manifested by the trauma group or a member is best observed (and understood) than confronted.

i. In face of the collapsed self that follows catastrophic loss there is often a necessary denial.

ii. Short of any resistance becoming self-destructive or group destructive, a verbalized understanding by the leader of the need for protection is often experienced as empathy.

- iii. Often denial or distortion is indirectly addressed by the reaction of other members who share a similar loss.
 - b. In psychotherapy groups the adaptive nature of defenses is frequently overridden by the costliness to daily living so that interpretation of them is undertaken, albeit with respect, sooner.
8. Dissociation as extreme protection
- a. Definition of dissociation: Dissociation is a victim's movement into "an altered state of consciousness, into a state of not feeling and not knowing, a state of "not me" (depersonalization), or a state in which the whole world feels "unreal" (derealization) for the purpose of avoiding psychological disintegration in the face of intolerable feelings, memories, or aspects of self related to trauma. (Pearlman & Saakvitne, 1995, p. 121-122)
 - b. Although not a defining marker for trauma, dissociation occurs more frequently when an individual has a trauma history. The following response to dissociation is appropriate in a trauma group (Pearlman & Saakvitne, 1995):
 - i. When dissociation is manifested in group the therapist, as well as all members, can feel anxious, and helpless.
 - ii. If the therapist understands and educates the group to normalize and view dissociation as a self-protective response, the therapist can provide empathy and containment for the member and the group, i.e. the therapist should not allow dissociation to occur without it being addressed in the group in a helpful way.
 - iii. Inviting an understanding of triggers of trauma, using grounding techniques to re-establish reality, and re-establishing the group as a safe place in the here and now are important tasks of the leader dealing with the dissociation of a group member.

VIII. COMMON COUNTERTRANSFERENCE RESPONSES OF LEADERS OF TRAUMA GROUPS

- A. Feeling Overwhelmed
 - 1. This is a common feeling in the face of multiple expressions of horrific trauma and loss. It is often manifested as:
 - a. Anxiety
 - b. Dread of meeting
 - c. Distractibility

- d. Physical discomfort
 - e. Excessive planning or rumination about the group content
 - 2. In face of overwhelming anxiety, a leader may feel dissociative symptoms of
 - a. Numbing
 - b. Confusion
 - c. Perceptual distortions
- B. Defenses Against Feeling Overwhelmed
 - 1. Over-distancing
 - 2. Rigid neutrality
 - 3. Avoidance of interpersonal engagement
 - 4. Intellectual response to the traumatic event rather than the person
 - 5. Extended use of silence
 - 6. Verbalization of concrete re-assurances
- C. Feelings of Depression and Sadness
 - 1. This is often reflected as over-identification with group members' feelings without being able to distance from them in one's personal life.
 - 2. Danieli (1984) in referring to those working with Holocaust survivors spoke of caretakers as being "engulfed by anguish" and "sinking into despair," such that they could not access a sense of hope (p. 30).
- D. Fear of Connecting with Loss and Desperation
 - 1. The leader and/or members may exhibit the following verbal or non-verbal messages:
 - a. To feel better
 - b. Be less frightened
 - c. Get on with life

- d. Reassuring the group that things will get better
- E. Fear of Triggering Personal Traumatic Responses to the Graphic Details of Trauma
1. At times a leader experiences this fear or colludes with this fear in certain group members by silencing certain members, changing topics, controlling the group process, over intellectualizing.
 2. Wilson & Lindy (1994) found “empathic withdrawal” (avoidance) e characteristic of those leaders who have been spared personal catastrophe, because their world view preserves the ideas that life is decent and just. They found “empathetic repression,” where the therapist both withdraws and denies the significance of the withdrawal, and “empathic enmeshment” (over-involvement) as more characteristic of previously traumatized therapists.
- F. Feeling Angry
1. The majority of trauma specialists note that anger and hostility is a significant problem in traumatized populations and a major counterreaction in trauma therapists. (Dalenberg, 2000)
 2. The group leader may not only feel angry for the patient who has been traumatized, but often angry *with* the patient or group whose response to the leader leaves him/her feeling abused, helpless, dismissed or unappreciated so that retaliation or retreat can be enacted.
 3. Recognizing that anger is an inevitable aspect of trauma work, the leader may be better prepared to deal with his/her countertransference response. Awareness of Countertransference anger can then facilitate the therapist’s ability to respond from option such as the following:
 - a. Addressing with concern and interest the group member’s angry feelings toward him/her.
 - b. Maintaining the safety of the group by setting limits on verbal abuse or acting out.
 - c. Moving to a whole group intervention, i.e. asking how other group members feel, which can serve to dilute primitive rage.
 4. Examples of Handling Anger
 - a. If the group leader finds himself/herself becoming increasingly angry in the face of relentless attack by a member, rather than holding back or becoming

retaliatory, it may be advisable that he/she try to understand and disclose his/her feelings in a way that invites a more constructive exchange.

- i. "I'm feeling angry by the continued taunting."
 - ii. "I'm not sure that it is helping either of us to continue with this exchange."
 - iii. "Can you tell me what you are feeling in another way?"
 - iv. "Can someone else in the group help?"
- b. It is often the expression of authentic feelings of anger by the therapist that establishes his/her genuineness, verifies the reality of the patient's impact on others and precludes the split of therapist as all good and patient as all bad. (Epstein, 1977)
- c. Sometimes two members will attack each other as a way to protect the leader and maintain his/her idealization.
- d. Sometimes a group will scapegoat a single member as a way to mask hostility to the leader or its open expression in the group.
- e. In all cases it is the leaders' responsibility to recognize and address it.
- i. Often the leader can try pulling the anger back to self: "I think the attack of Jim has something to do with protecting me;" or try interpreting the scapegoating: "Joe what would the group do if they didn't have you to get angry with?" In so doing, the leader confronts the dynamic and invites working through and integration of anger within relationships.
 - ii. Moving the anger from the "here and now" to the "there and then" is another way to modulate it, invite an understanding of the impact of the historical, and as such expand the group's capacity to know self and others.
- f. Sometimes anger is a manifestation of the leader's own anxiety or feelings of helplessness. When it shows as anger on behalf of the group members, it may result in premature pushing of anger or action in group members.
- g. For a time, victims of trauma are often stronger in the context of the group than they are in the outside world and the premature invitation to act forecloses on healing.

h. A leader having difficulty working with his/her anger might seek consult from colleagues, a supervisor or his/her own therapist. The power of group is that it makes the necessary expression and processing of anger safe and reduces the torturous guilt that often follows its unregulated expression. (Buchele, 1995)

G. Fear of Anger or Conflict

1. Fearing that he/she will add to the pain of traumatized group members, the leader may at times deny or avoid anger or conflict in the group or in certain members.

a. Danieli (1981) working with Holocaust survivors, observes that sometimes this is manifested as “overgeneralizing” of feelings to all members or failure to recognize individual differences in victims’ responses to trauma.

b. Such avoidance may collude with a trauma group’s need to maintain the safety of sameness and attunement.

c. In the case of a mass trauma there may be a need to displace anger away from deceased family members to outside the group.

d. Eventually it becomes important for the leader to look for opportunities to normalize the anger and give permission for the inevitable differences.

H. Feelings of Inadequacy

1. This is often engendered by the inability to change the traumatic event and its consequences for self and the group.

2. A leader can personalize, feeling the group is a failure when members verbalize their desperation that nothing helps.

3. The leader can have expectations of healing as reflections of his/her own worth.

I. Feelings of Exclusion: Particularly in a trauma group that shares the experience of catastrophe or loss (bereavement group), the leader might feel isolated, disconnected, not entitled to share as part of the group.

J. Feelings of Shame and Blame

1. Dalenberg (2000) reports that therapists often unwittingly question (or blame) victims for the numbing or non-response to their traumatization. An awareness of this often generates shame.

2. Danieli (1981) describes the therapist’s feelings of helplessness or bystander’s guilt as a source of shame.

3. Dalenberg (2000) notes: "It is the shame of the just, shame that any decent human being feels when forced to know how cruel human behavior can be, shame associated with the wish to push away any connection between ourselves and those who would commit such acts...."

K. Feelings of Guilt

1. Often the leader feels guilt for not having suffered as much, for having a spouse, a child, etc.
2. Herman (1992) suggests that there is a "witness guilt" much like "survivor guilt" when bearing witness to another's trauma. The result is often an attempt to compensate by limitless dedication.

L. The Need to Know

1. In facing trauma, therapists have the urge "To heal all, know all and love all." (Maltzberger & Buie, 1974, p. 627).
2. The leader, faced with the helplessness and lack of control resonating in a trauma group, often demands from himself/herself an excessive need to know despite an intellectual awareness that learning to live with and contain uncertainty is essential in trauma work.
3. The risk at times is an intellectualization at the cost of being in touch with the authentic feelings of bewilderment and disbelief that follow in the wake of trauma.
4. When the leader has also been victim of the catastrophe (such as 9/11) or experienced a similar tragedy, there is often the presumption of knowing how the other must feel. This imposition of the therapist's experience onto the group member precludes the understanding that comes by being willing "not to know" and can be a consequence of unresolved trauma responses in the therapist.

IX. ASSESSMENT OF COUNTERTRANSFERENCE

A. Identify the Countertransference

1. What are your conscious feelings (personal or related to the group)?
2. What are your associations in the session (personal or related to the group)?
3. Are these thoughts or feeling familiar, unusual, more extreme than usual, appropriate to the situation, persistent, anxiety producing?

4. Are these feelings and thoughts outside of your awareness (unconscious) manifested in dreams, fantasies, bodily sensations, behavior inside or outside the group?
 5. Is their evidence of defending against feelings? (confusion, numbness, intellectualization, distractibility, anger, attempts to avoid or over-control process etc.)
- B. Determine the Source of this Countertransference
1. The trauma or traumas presented by the group/individual member.
 2. The group/individual member's response to trauma (PTSD symptoms).
 3. The group/individual member's response to you, to each other.
 4. The group/individual member's lack of an overt response or an inappropriate response to the trauma, to you, to each other.
 5. Your own identity, sense of self, personal life circumstances, personal history of trauma, your psychological needs, your coping skills.
 6. Your professional identity, level of training, level of experience, professional expectations and goals.
 7. Your current circumstances at work or at home.
- C. Determine the Function of the Countertransference
1. Does it serve a defensive need?
 2. Does it represent empathic attunement?
 3. Does it represent an identification with the group/individual members?
 4. Does it identify what is being avoided or split off by the group/individual members? (Example you are the only one feeling anger in a bereavement group)
- D. Determine the Impact of the Countertransference
1. Does it facilitate your understanding of the group/individual member?
 2. Does it facilitate understanding of self in terms of needs, history, self expectations, etc.?
 3. Does it facilitate your role as leader?
 4. Does it impede your role as leader?

- E. Access the Use of Your Countertransference
 - 1. Does it illuminate the need for consultation or supervision?
 - 2. Does it underscore the need for self-analysis or some personal treatment?
 - 3. Should it be disclosed to the Group?

X. DISCLOSURE OF COUNTERTRANSFERENCE

A. Victims of trauma want to feel connected with others, including the leader. The careful and selective use of disclosure in trauma work can facilitate this.

- 1. The risks are over-disclosure may be experienced as burdensome, hostile or confusing to the group and underutilization of disclosure—silence, distancing and avoidance—which may be experienced by the group or individual member(s) as judgment, disgust, fear, etc.
- 2. It is crucial for the group therapist to understand his/her countertransference before evaluating whether or not disclosure is appropriate.
- 3. Self disclosure can involve the therapist's personal information or the therapist's emotional response to group members.

B. When discerning whether therapist self- disclosure to the group or individual patient is appropriate, consider these three questions. (Dalenberg, 2000)

- 1. Is the reason for disclosure appropriate, in that it is information relevant to the client's need to know rather than the therapist's need to discharge affect, to protect his or her own ego, or to advance his or her own needs?
- 2. Are the method and timing of disclosure appropriate, offered in the manner most likely to be perceived as information rather than as an assault, mindful of the client's ability to hear?
- 3. Is the type or content of countertransference disclosure appropriate, responsive to client needs, and unlikely to overwhelm the client?

XI. UNDERSTANDING VICARIOUS TRAUMATIZATION: THE RISKS OF CARING

A. Definition of Vicarious Traumatization

- 1. Vicarious traumatization was originally defined as “the transformation of the therapist's or helper's inner experience as a result of empathic engagement with survivor clients and their trauma material.” (McCann & Pearlman, 1990)

2. Vicarious traumatization is an inevitable occupational hazard. It is not something our patients are doing to us or we are doing to ourselves. It is a process not an event. It includes our feelings and our defenses against those feelings. It comes with connection to and empathic understanding of those traumatized. The goal is to apply self-care rather than pathologize this inevitable fallout of the caretaking (Pearlman, 1990; Saakvitne & Pearlman, 1995).

B. Comparison with Secondary Traumatic Stress, Secondary Traumatic Stress Disorder and Compassion Fatigue

1. Secondary traumatic stress (STS) is seen as the natural, consequent behaviors and emotions resulting from knowledge about and/ or helping or wanting to help a traumatized or suffering person. Whereas “burnout” is seen as something that emerges gradually as a result of emotional exhaustion, STS can emerge suddenly and has with it more of a sense of helplessness, confusion and isolation (Figley, 1999).

2. Secondary traumatic stress disorder is a syndrome of symptoms nearly identical to the symptoms used to describe PTSD, except that the trauma involves the concern and care of a traumatized person (Figley, 1999).

3. Compassion fatigue has been generally used by the medical community to explain the stress and fatigue of duty-related experiences. (Figley, 1999) Because compassion is seen as deep sorrow for another plus the drive to alleviate pain or its cause, it has been considered appropriate to other caretakers. According to Figley (1995), it is the experience of empathy and degree of exposure that causes some to develop it and others not.

4. Vicarious traumatization is a process much like Secondary Traumatic Stress Disorder and Compassion Fatigue (Figley, 1995; Figley, 1999; Strumm, 1999) in that it includes symptoms parallel to the PTSD suffered by survivors. In addition, however, it involves a pervasive impact on the therapist’s view of self, view of the world, belief system, interpersonal relationships, cognitive, emotional and spiritual functioning (Saakvitne & Pearlman, 1995). It disrupts the therapist’s sense of vibrancy, trust and hope.

C. Comparison with Countertransference

1. Countertransference is present in all therapies but it is temporarily linked to a certain session, event or issue that reacts with the therapist’s internal or external life.

2. Vicarious traumatization is specific to trauma therapy and is the result of the cumulative effect of on-going trauma work. Its effects are persistent and felt beyond a particular therapy, both in other therapy relationships and in the therapist’s personal and professional life (Saakvitne & Pearlman, 1995).

XII. SIGNS AND MANIFESTATIONS OF VICARIOUS TRAUMATIZATION

A. Cluster Symptoms of PTSD (Secondary Traumatic Stress)

1. Hyperarousal: Inability to sleep, relax, tearfulness, irritability, vulnerability to overstimulation from people, crowds, television, panic, anxiety, and dissociative symptoms.
2. Re-Experiencing: Intrusive images, thoughts or memories of what you have been told; acting or feeling as if you experienced the trauma; nightmares, flashbacks of personal historical trauma.
3. Constriction (avoidance or numbing): Little or no affect; avoidance of anything emotional or upsetting; avoidance of social connection, places and things formerly of interest; experiences of lifelessness and disinterest in most things; wish to be alone; fear of the future.

B. Pervasive Changes

1. Altered view of self: lowered self-esteem, self-doubt
2. Altered view of the world: dangerous, unfair, doomed, unpredictable
3. Changes in spirituality: dampened belief system whether organized religion or meaning of life, nature, etc.
4. Difficulty tolerating feelings: shame or self-blame
5. Inability to use good judgment: no longer feeling able to show mastery, make things happen, make decisions
6. Dampened creativity: less use of play, fantasy, dreams, imagination
7. Change in perspective: difficulty thinking positively about the future, obsessed with trauma
8. Difficulty self-soothing: inability to use former talents or interests (music, art, writing etc.) to relax.
9. Increased sense of vulnerability: fear of travel, mistrust of people, fear of loss of control, etc.
10. Difficulty with intimacy: changes in ability to enjoy and be close to family, friends, and partners

11. Difficulty enjoying life: inability to relax, enjoy people, events, holidays, talents, passions

XIII. PROFESSIONAL FACTORS CONTRIBUTING TO VICARIOUS TRAUMATIZATION

A. Apart from a therapist's personal history, personality or current situation there are certain factors of the work situation that contribute to vicarious traumatization.

1. Lack of training and understanding of PTSD, unanticipated traumatic loss, the grieving process, trauma recovery etc.
2. Lack of group training
3. Lack of supervision (individual or group) for training, support, disclosure, containment and transformation of traumatic material
4. Lack of a (work) peer group for mutual support, validation, and ventilation of feelings
5. Lack of attention and concern by agency or institution (employer) regarding the impact of traumatic work on professionals
6. Unbalanced caseload: For example, all trauma survivors with similar trauma in group or individual work without the psychological break, distancing and processing that a diverse caseload offers.
7. Heavy caseload interfering with personal responsibilities and personal life pursuits
8. No significant opportunities in the daily work schedule for physical and emotional stress relief (lunch, peer group supervision, on-line support, etc.)

XIV. AMELIORATING VICARIOUS TRAUMATIZATION

A. Those who have worked with trauma survivors and have been privileged to contain and bear witness to others' pain know that they "open themselves to a deep personal transformation." (Pearlman, 1999, p.51)

1. In a positive way their connections with self and others and their view of life can be greatly deepened and enriched.
2. In a negative way, they are assaulted by cumulative trauma in a manner similar to the survivors they work with.

B. Guidelines of Self-Care for Ameliorating Vicarious Traumatization (Saakvitne & Pearlman, 1995; Pearlman, 1999; Williams & Sommer, 1999; Stamm, 1999)

1. Maintain a balance of work, play and rest to offset the physical and emotional fatigue of trauma work.
2. Clarify and underscore your personal sense of self by pursuing activities that reinforce all aspects of your identity—spouse, parent, tennis partner, soccer coach, gourmet cook, etc.
3. Identify personal coping skills for reducing stress (time alone, yoga, listening to music, recreational reading, etc.).
4. Get supervision from someone who understands trauma work and group work with trauma.
5. Identify resources at work for debriefing and support.
6. Identify and address what you need physically, psychologically, financially in the workplace.
7. Take care of yourself physically; diet, sleep, and exercise.
8. Identify relationships that offer understanding and support.
9. Consider your use of spirituality from organized religion to a more personal joy of nature, awareness of non-material values in life, etc.
10. Nurture self by being taught something new and unrelated to your work—lessons in bridge, golf, knitting, etc.
11. Know and accept your limitations personally and professionally.
12. Identify those issues, patients, traumas that trigger countertransference difficulties. Get supervision or therapy if needed.
13. Maintain your personal boundaries of time for family, self, rest, and play.
14. Accept the uneven timeline for healing in self and patients.
15. Seek professional resources outside of your work place for support and help—conferences, on-line support, professional associations.

XV. CONCLUSION

Perhaps our greatest challenge and privilege as therapists and group leaders is responding to those who trust us with their trauma. In the aftermath of 9/11, most group leaders were seized by the doubt of what they could offer in the face of unimaginable devastation and awakened by the realization of how much they were needed.

We know that to work effectively with those who have been traumatized, one must be willing to: enter into their experience; be empathically attuned to the terror, shame, vulnerability, rage, and loss; and enter the disconnection and disempowerment that comes with trauma. As such, our countertransference becomes our greatest asset and our greatest liability. To truly feel with our groups inevitably expands who we are while at the same time putting us in harm's way.

This module has underscored the impact of trauma on the countertransference of the group leader and has stressed the necessity for recognition, and assessment of countertransference as crucial to the effectiveness of their work and their own self-care.

This module has further emphasized that on-going, unsupported group and individual work with trauma without supervision, training, peer support, appreciation, permission to rest, diverse caseload, etc. results in the cumulative impact of trauma called vicarious traumatization. This is manifested not only by many of the same signs and symptoms of PTSD suffered by survivors but by the more persistent inner transformation of the group leader in terms of view of self, view of the world, belief systems, capacity to feel resilient or to have hope. Whereas countertransference manifests in specific situations and is temporary, vicarious traumatization persists and is evidenced across professional and personal functioning.

While we recognize that this is the fallout of the specialized work that we choose to do, we also know that such vicarious traumatization can be ameliorated by the recognition of its impact, the group leader or therapist's balance of his/her own professional and personal needs, and the recognition and support of professional and institutional resources in addressing and offsetting the risks of caretaking.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed) (DSM-IV-TR). Washington, DC: American Psychiatric Association.
- Boulanger, G. (2002). Wounded by reality: The collapse of the self in adult onset trauma. *Contemporary Psychoanalysis*, Vol. 38, No. 1, 45-76.
- Buchele, B. (1995) Etology and management of anger in groups: A psychodynamic view. *International Journal of Group Psychotherapy*, 45(3) 275-285.
- Compassion Satisfaction/Fatigue Self-Test for Helpers, B. Stamm & C. Figley (in press) <http://www.isu.edu/~bhstamm/tests/htm>.
- Dalenberg, C. (2000/2001). *Countertransference and the Treatment of Trauma*. Washington, DC: American Psychological Association.
- Danieli, Y. (1984). Psychologists' participation in the conspiracy of silence about the Holocaust. *Psychoanalytic Psychology*, 1:23-42.
- Epstein, L. (1977). The therapeutic function of hate in the countertransference. *Contemporary Psychoanalysis*, 13:442-461.
- Figley, C. (1995/1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. Stamm (Ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*. Lutherville: Sidran Press, pp. 3-28.
- Figley, C. (Ed.) (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel.
- Foy, D., Eriksson, C., & Trice, G. (2001). Introduction to group interventions for trauma survivors. *Group Dynamics: Theory, Research and Practice*, Vol. 5, No. 4, 246-251.
- Herman, P. (1950). On countertransference. *International Journal of Psychoanalysis*. 31:81-84.
- Herman, J. (1992). *Trauma and Memory*. New York: Basic Books.
- Johnson, D., & Lubin, H. (2000). Group psychotherapy for the symptoms of posttraumatic stress disorder. In R.H. Klein, & V.L. Schermer (Eds). *Group Psychotherapy for Psychological Trauma*. New York: The Guilford Press, pp.141-169.
- Kernberg, O. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association*, 13:38-56.
- Klein, R., & Schermer, V. (2000). *Group Psychotherapy for Psychological Trauma*. New York: The Guilford Press.
- Levine, P. (1997). *Waking the Tiger Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences*. Berkeley: North Atlantic Books.
- Livingston, M., & Livingston, L. (1998). Conflict and aggression in group psychotherapy: A self psychological vantage point. *International Journal of Group Psychotherapy*, 48(3), 381-391.
- Maltsberger, J., & Bure, D. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry*. 30, 625-633.
- McCann, I., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3 (1), 131-149.
- Ormont, L. (1980). Training group therapists through the study of countertransferences. *Group*, Vol. 4, No. 4, 17-19.
- Ormont, L. (1992). Subjective countertransference in the group setting: The modern analytic experience. *Modern Psychoanalysis*, 17(1), 3-12.
- Pearlman, L., & Saakvitne, K. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: W.W. Norton.

- Pearlman, L. (1999). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. Stamm (Ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*. Lutherville, MD: Sidran Press, pp. 51-64.
- Roth, B. (1990). Countertransference and the group therapist's state of mind. In B. Roth, W. Stone & H. Kibel (Eds.) *The Difficult Patient in Group*. New York: International University Press.
- Racker, H. (1968). *Transference and Countertransference*. New York: International Universities Press.
- Saakvitne, K., & Pearlman, L. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: W.W. Norton.
- Stamm, B. (Ed.) (1999). *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*. Lutherville: Sidran Press.
- Williams, M., & Sommer, J., Jr. (1999). Self-care and the vulnerable therapist In B. Stamm (Ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*. Lutherville: Sidran Press.
- Wilson, J., & Lindy, J. (1994). *Countertransference in the Treatment of PTSD*. New York: The Guilford Press.
- Winnicott, D. (1965). *The Maturation Processes and the Facilitating Environment*. New York: International Universities Press.
- Wolin, S., Deserta, A., & Hefner, K. (2000). *A Leader's Guide to the Struggle to be Strong: How to Foster Resilience in Teens*. B. Goldsmith (Ed.) Minneapolis: Free Spirit Publishing, Inc.
- Ziegler, M., & McEvoy, M. (2000). Hazardous terrain: Countertransference reactions in trauma groups. In R. Klein & V. Schermer (Eds.) *Group Psychology for Psychological Trauma*. New York: The Guilford Press, pp. 116-137.