How Psychotherapists Cope With Their Patients' Trauma*

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Following a redefinition of trauma after violent mass-catastrophes, and detailing the dilemmas in post-traumatic (p.t.) psychotherapy, the author presents two cases (a crisis intervention in a combat-stricken soldier of the Yom Kippur War of 1973, and a long-term therapy with a middle-aged child survivor of the Holocaust) for highlighting his own reactions to the emotional impact of listening to the patients' past exposure to extreme aggression and massive loss. This paper focuses on the therapist's dilemma in facing the threats to one's own existence and yet maintain the ability for empathy and solidarity with the victim. After further reviewing some previous work on attitudes of Israeli therapists to trauma, recommendations are formulated for conducting p.t. therapy and for p.t. therapeutic services.

This paper deals with the problem of treatment of post-traumatic states, acute and protracted, under conditions of co-traumatization and retraumatization of the therapist after exposure to the trauma of post-traumatic victims. This problem has relevancy for the treatment milieu and for the outcome of post-traumatic interventions.

Introduction

Post-traumatic stress disorder and other "complex post-traumatic states" (J. Herman, 1992) have been defined as medical conditions. However, the post-traumatic person's human environment does not remain immune, and may indirectly become affected or, meta-

* With remarks on the organization of post-trauma services in Israel.

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phorically, "infected," by the trauma. Examples are:

1. The co-traumatization, through "transgenerational transmission" of the post-traumatic experience to the second generation of the Holocaust (Jucovy, et al, 1982).

2. Contamination of spouses, a phenomenon described as "secondary traumatization" during the aftermath of combat-trauma (Solomon et al, 1992).

3. Response of society to trauma, including rejection and denial, which eventually add to the original trauma of the victim. This phenomenon is known as "secondary victimization." (For descriptions of examples in Israeli society, see Ayalon, 1988; Dasberg, 1987, 1992 [b, c]).

4. "Vicarious traumatization," lately diagnosed in psychotherapists of civilian trauma victims of rape and robbery (McCann et al, 1990). This is a syndrome seen among professionals and is characterized by the acquisition of post-traumatic symptoms through close emotional contact with patients, and the persistence of those symptoms between clinical encounters. This *persistence* of imitated symptoms is in contradistinction to other uncalled-for emotional therapist responses which do manifest themselves only *during* the encounters. These are subsumed under the term "countertransference."

The Concepts of Identification and Empathy

Whereas vicarious traumatization and countertransference signify excessive identification of which the therapist initially is *not* aware, empathy (or, preferably, "*clinical* empathy" — Berger, 1987) is an additional and better-controlled method of coming near to the post-traumatic patient's trauma (Parson, 1988; Catheral, 1989). Therapeutic empathy is rooted in the therapist's ability to resonate affectively with the patient, while simultaneously remaining aware of his own feelings (Basch, 1983). The empathic therapist incessantly oscillates between (Book, 1988) neutrality and affective nearness, and does not hesitate to take the side of the patient.

Kohut defines empathy as "vicarious" introspection, that is, as experienced through the other. However, the attempt to empathize with the inner world of the post-traumatic person who has come eye-to-eye with death may be a scary, uncanny (in German, "unheimlich," S. Freud's expression) and hazardous experience, which may tempt the therapist to turn away.

Some Dilemmas

Although one should avoid turning away and overtly pulling back from the victim, too close a contact, on the other hand, would seem to constitute an untoward experience leading to excessive warding-off and closing-off in both patient and therapist. The common psychotherapeutic dilemma between coming too close and staying apart gets a more decisive edge in post-traumatic encounters. But is this excessive warding-off of emotions entirely avoidable? Even under the best circumstances? And what about the unspoken responses of those therapists who were previously traumatized themselves? And so many are, in our era, and in this country, subsequent to political persecution elsewhere, or military disasters here. Even those who deemed themselves to be mere bystanders or onlookers might not escape scot-free.

What determines whether (re-) traumatization of therapists will help or hinder the therapeutic interaction? Or, to put it differently, the question is:

Where does the vicarious or countertransferential co- (or re-) traumatization end, and the empathic turn around begin? "Turn around" here means: To turn around to the patient's needs. Eventually, the patient too is expected to turn around and give up his narcissistic entrenchments.

Turning away from these painful (and, in the opinion of some, even disrespectful) questions concerning the therapist's own hurt may have a disastrous outcome for the post-traumatic therapeutic climate. What should be avoided by all means is the avoidance of closeness with people after trauma, which is in any case an all-too-common phenomenon, among professionals and non-professionals alike (as will be discussed below).

Aims and Methods

In this paper the above problems are explored by turning inward to the personal experiences of the therapist, in this case, those of myself. Unluckily (or luckily, depending on the point of view), I had the opportunity of a varied experience with trauma in this country. At a later phase, subjective attitudes of other professionals were also explored in a series of pilot studies.

Using the insights to be gained by these subjective methods, this paper will conclude with recommendations for post-trauma services in Israel. (For reviews of *objective* methodological material on post-traumatic statistics as a basis

for organizational recommendation, see previous publications (Dasberg, 1987 [a, b]; Dasberg, 1991). The present one serves merely as a complement to these).

Before opening up my heart and soul, it may be opportune to dwell for a moment on the concept of trauma and the goals of its treatment, focusing primarily on trauma after mass disasters.

Trauma: A Concept

According to the Greek dictionary, trauma means wound, for instance, that of a soldier. It also means damage (such as to the hulls of ships), and also a blow, a disaster, a defeat. All these express very concrete events.

In psychology, trauma means wounding by intrusion or breaking through a hypothetical stimulus barrier, and also an incisure in the life course or a break in an existential sense.

In the social dimension, trauma refers to a discontinuity or alienation from what was before, or a loss of a sense of belonging.

Remaining in a protracted state of being traumatized also means to feel entitled to compensation for losses incurred, as well as for narcissistic injuries, by way of revenge, payment or sacrifice, or at least an apology, a recognition. These are culturally regulated rituals aimed at binding aggression and at reconciling victim and society. Failing to achieve reconciliation leads to the victim's despair or to a violent vendetta (of which "rente-neurosis" is only one, clinically relevant, expression).

As long as a settling of accounts or appeasement with the aggressor (or his replacement) has not taken place, nothing will be forgiven or forgotten, and the traumatized ones remain traumatized.

These anthropological aspects of trauma have especially become conspicuous after violent political catastrophes or military disasters, and other modern forms of human violence. Massive human violence is characterized by (Dasberg, 1987[a]):

1. Massive *death* and *loss*.
2. Encounter with unbelievable *horrors*.
3. Gross injustice *undermining* the basic *trust* in the other(s), and, finally,
4. A *break* with the familiar world as it was known before the disruptive violence took place. One becomes a stranger in one's own life course.

Psychic trauma in this sense, that is, after violent political catas-

trophe, can be considered as an endemic condition in the civilized world of the twentieth century. This also pertains to those who came to live in this country or were born here, including those who later became psychotherapists, and to whom the traumatized ones turn for posttraumatic understanding and treatment. This, admittedly, not only sounds complicated, but also foretells complications in the therapeutic interactions to come, as the following clinical example illustrates:

Trauma of the Battlefield

In October, 1973, while serving as a military psychiatrist in an army center for battle-shocked soldiers, I met a 35-year-old reservist (the case is mentioned in Dasberg, 1976). This soldier did not come to my consultation room like the others, but I had to look for him each day in the garden where, most of the time, he could be found sitting on a small bench. He hardly said anything; he did not appear to hear me speak to him.

Later I understood that my officer's insignia must have made him convulse with anger (as will be seen below). He did speak briefly with two younger soldiers who, like him, were evacuated from the battle zone. There we were, the three of us, facing, in silence, the taciturn, sombre soldier. What follows is his story, as I was able to piece it together:

In civilian life he is a diamond dealer. His reserve assignment in the army was as a driver in a unit of the regular infantry where all officers and soldiers were about 10-15 years younger than him.

On October 6, 1973, the unit was stationed in the bunkers of the Bar-Lev line, along the Suez Canal. At the outbreak of the artillery barrage which signalled the start of the Egyptians' assault, he happened to be out for a walk in the fields nearby, together with his lieutenant and two soldiers. They hurriedly took cover and for hours were forced to listen over their open radio receivers as their comrades were being overpowered, shot and killed.

Unwittingly, he related to me how one of them, unbeknownst to him a cousin of mine, died in the same spot where I had served as a medical officer some 3 1/2 years earlier. Therapists who deal with traumatic experiences are never guaranteed protection or immunity from shocking news from the *real* world.

Towards evening of that long day, the four of them decided to run for their lives, but were fired upon. In their flight they threw

away their equipment and almost gave him up too, but then, at the last moment, his officer, the lieutenant, grabbed him and brought him to safety. He took that risk, a humane gesture in a catastrophic situation. Later, after dark, they approached a friendly tank encampment, but with no means to identify themselves, a shell was fired at them, killing his officer and one of the other men, and he alone survived, unharmed. The tank officer, a major, simply apologized and evacuated him. This all-too-laconic tank major thus killed the other officer who had saved the elderly, straggling soldier who was to become my patient.

And there he was, after two weeks, dumbfounded and powerless with held-back rage. But he did say a few things, such as wishing to take revenge and kill the major. This wish had the intensity of an idee fixe. I and the two other men listening to his story helplessly confronted him, unable to reach him emotionally. The situation reminded me of the Biblical story of Job and his three friends who, like us, with growing impatience, failed to have him, Job, admit his sins.

He talked only to the army Rabbis. (Their responsibility is to bury the dead and also to investigate the situation of the missing-in-action). He talked with them alertly, and only a hint was needed for him to grasp what they were aiming at. He poured forth his story to them in the greatest detail. He responded to their inquiries with a completely different personality, ignoring my presence, forgetting that he had ever seen me before.

This kind of post-traumatic personality split is not that uncommon after a near-death experience. At this point, the Rabbis met his needs better than the therapist. With the latter, he remained shattered, fragmented. With the field Rabbis, however, he reunited with the departed, while the therapist did not know how to meet him there, in that other territory, where the dead are still alive.

Our contact nevertheless improved after his confessions to the clergymen. It was then that I heard more about his preoccupation with revenge. I asked another patient, another tank officer evacuated from the same sector, if the story of the shell firing made any sense, since at first I could not believe these horrors. This is our problem as bystanders or as those listening to horrible stories; we simply do not believe them. But my informant did indeed confirm the story. He even knew the name and possible location of this major, the killer.

I told my patient that the identity and location of this major were

known. I did not believe it was my duty to hide anything from him. I had to either risk this or give him up. Total solidarity with the traumatized person is, after all, in my opinion, an absolute therapeutic necessity in post-traumatic states. Total solidarity, but not necessarily total identification!

He answered, however, that he did not wish to hear it yet. Following this, his *delusions* (for, in hindsight, this was indeed what it was) disappeared, and our mutual understanding improved. Shortly after this I was assigned to another site, and I lost track of him.

Two years later he contacted me again. He told me that he had been unable to work, but had been found by the father of his dead officer who had asked him to record his memoirs. Although he was not a writing kind of person, as he described himself, he did so with great effort and pain, because the officer's father needed it to commemorate his son's memory. As he wrote down the story he had again remembered me, and also who was the person still owing him $30,000 for diamonds he had handled on the eve of the war. He had already contacted the diamond exchange, and would be able to work again. He thought it was important to tell me all of this, and to let me know that he had not forgotten my efforts, now that he had come full circle.

This case demonstrates the following five aspects:

1. A vital ingredient of post-trauma therapy is the *story*, the "narrative", according to present-day literature. The story restores meaning to chaos. Retrieval and reconstruction of the story is, and always was, one of the cornerstones of psychotherapy (Dasberg, 1992).

2. The second basic principle of post-trauma therapy is to enable the victim to rejoin the community from which he had been alienated. Acknowledgement and acceptance by others restores the shattered person and his meaning as a human being.

On second thoughts, it is not the reconstruction of the broken story that is the main paradigm for treatment, but restoration of the broken *person* in a meaningful social context (Dasberg, 1991). Luckily there exist in our culture preordained ways for bringing back shattered people: The Shiva*, the activi-

* Shiva: Hebrew word for "seven," i.e., the seven days of ritual mourning following burial or news of death.

ties of the Hevra Kadisha** (in this soldier's case, the army Rabbis), and as in this case the grieving father's commemoration rituals.

The therapist, in dealing with post-traumatic cases, must be able to go beyond his / her usual interactions, and should lead the patient back into society. Social alienation is by itself trauma; the therapist is the representative of that society, and he leads the patient back into it.

3. *The Problem of Aggression*: The patient's hidden rage, manifested here as a wish for revenge, is a reaction to defeat and helplessness. My acceptance of his revenge fantasies contributed to more tranquility. To give up the wish for revenge is the beginning of a return. This process is superbly described by Judith Herman in her recent book *Trauma and Recovery*.

4. *Empathy*: The ability to participate in the emotional world of the one who is traumatized is a precondition for therapeutic empathy.

However, the *risk* of empathy lies in what Kohut describes as "the regression in the service of the empathy" (i.e., the risk of loss of the necessary emotional distance), and this is not without danger for the therapist, because the therapist takes in and absorbs the aggression, and may identify with the aggressor. But at the same time we also find here the kernel of what becomes the personal experience with trauma and its therapeutic possibilities.

5. *Failure*: Job's three friends, Elipaz, Bildad and Tsofar, demanded from Job a confession of his sins, accused him and did not show empathy; accordingly, they did not succeed in their attempts to relieve Job's suffering. At the end, they were admonished by God (i.e., the cosmic Supervisor), and had to make sacrifices of appeasement in order to be forgiven for their lack of understanding.

As with Job's friends, so it was with the three of us (the therapist and the two other participants in the meetings, the two soldiers) — we expected the patient to talk. When a breakthrough finally came, the therapist could resonate with the patient's anger, but a full-fledged therapeutic empathy had not yet become apparent in this case. I could not yet use my empathy therapeutically; a loving understanding of his real needs was still lacking.

Thus, something more now has to be said regarding the problem of empathy and the working-through

** Hevra Kadisha: The society of religious men taking care of the Jewish rituals of burial.

of the therapist's own shocking emotional experiences, as well as his (or her) co-traumatization or retraumatization when confronting the trauma patient.

A Child-Survivor of the Holocaust

Whereas the above case presentation concerned an acute trauma in the wake of shocking events resulting in Post Traumatic Stress Disorder (P.T.S.D.), the following case, in contrast, belongs to the category of the so-called complex posttraumatic states. This is a newly-formulated diagnostic category of chronic posttraumatic personality disorders, depression, identity crises and other *non*-typical manifestations of P.T.S.D. (J. Herman, 1992; DSM IV-Option Book).

Complex posttraumatic states often occur or recur after many years of apparent good health, in many cases as a result of sequential or cumulative traumas in childhood or adolescence (Keilson, 1989).

Delayed complex P.T.S. is increasingly recognized in cases of so-called "child survivors" reaching middle age (Keilson, 1989; Dasberg, 1992). One of them, a very creative but disturbed university professor, came to me in order to treat some current symptoms, but also, and mainly, in order to speak about the war years (1940-45). Born in 1941, he could hardly remember anything. His parents, who eventually perished in the concentration camps, managed to find a hiding place for him in time, with a Christian family.

After the liberation, a surviving aunt and uncle took him into their home, but did not tell him until he was 12 years old that they were not his real parents. He experienced the final disclosure as an insult, and he closed up emotionally — for a long time. He became a reticent and suspicious youngster.

Although apparently highly motivated towards therapy, and always arriving for each session exactly on time, he nevertheless began to reject me by isolating his emotions and speaking with a sheer, unbearable monotony, as if from behind a mask. He closed once again, an apparent repetition of former defense maneuvers acted out in the transference.

At my wits' end, and out of my own (countertransferential) helplessness, I let myself be distracted by my own fantasies. I found myself back in Kenya where I had once participated in a photo safari — a clean country, untouched by history or the Shoah, a Paradise. I had been happy there and yet had nightly dreams of my own perished

family, and of my murdered father (in that same war, '40-'45). These were actually pleasant and consoling nightly encounters in that untouched "Paradise." I basically re-experienced, in that therapy session, a brief recapitulation of my own "mourning."

I returned to the reality of the therapy situation, with the patient having just said, "I always felt lonely during those happy family gatherings [in the homes of other surviving aunts and uncles]; the many children were often asked, 'Who is your father, and who is your father,' and so on." But he, actually, was never asked those questions.

Thus, looking back now, it turns out that others knew what he himself did not; namely, that he had had another father. I than answered, "What a lack of 'koved' (Yiddish for respect) for your own father." His mask then disappeared, and he was quite moved; at last I had understood him. I must admit that I had also felt lonely and rejected in the presence of my patient. He drove me, as it were, far away into the wilderness, where I had found consolation, but, returning to reality this time, I had found the right words for him too, and that, moreover, in a jargon he had not heard since his childhood. He was touched in just the right spot, and it broke the ice. I had empathically acknowledged his injury, and recognized his need to be reaffirmed, as the son of a father. Here we have an example of empathy that became integrated in the therapy.

From that point on the therapy focused on the vanished father, the reconstruction of the story of the unknown lives and deaths of both his parents, the correction of his own identity as a father, and as a child, in the transference, and, last but not least, he could mourn the parents he never knew, of whose existence he could not have even guessed, and who had now both become real for him.

After two years of therapy, he could finally say the kaddish prayer in memory of his parents, and was deeply satisfied by this act.

This fragment from a post-traumatic therapy illustrates the following points:

1. The reconstruction of a meaningful story *and* providing a bridge back to the community from which one became alienated are both, as said before, the cornerstones of post-trauma therapy.

2. Empathy *and* loving understanding are the therapeutic means which may, however, also expose the therapist to regressive pulls and even to an onslaught of inner aggression due to his own forgotten injuries. The therapist's vicarious

traumatization or re-traumatization always remains a possibility.

The therapist's being able to work through and rework his own past is a hard-won ability, and a gift he brings with him to the therapeutic situation for the patient's benefit. The therapist must open himself up and let himself be moved . . . once again, as demonstrated by this vignette.

Exaggerated claims of neutrality are not what the patient, shaken in his most basic trust, is what s/he needs most. In order to feel safe enough, s/he needs trust and confirmation. Empathy and a dialogical openness secure this safety, as described in previous papers (Kron and Dasberg, 1989; Dasberg, 1992).

Where Do the Therapists Stand?

Perhaps the humanistically-oriented therapists see no new illumination here, except possibly for the following: Those therapists who grew up on European or Israeli soil are strongly involved in the political conflicts which lead to massive victimization and trauma.

This involvement is *not* a fantasy. The therapist may have been victimized in his/her own past or parents' past through identification; he may become a bystander, but never a totally innocent one (too uninvolved, for instance), or an accuser, or an admirer of heroism, which, however, alienates the supposed heroes even more.

Sometimes, therapists — like the society of which they are a part — stigmatize those who return from "there," or they behave as if they already know all about it, using psycho-dynamic, psychosomatic or psychiatric-forensic labels and formulae, refusing to be moved too deeply.

And others shamefacedly admit to themselves: "I never took part in terrible life events as did so many others who live in our era and country. We are only peeping-toms." And accordingly, they attempt to avoid the whole issue altogether. (This sort of reaction was clarified by Yael Danieli in her investigation of trauma-therapists' countertransferences).

If these conjectures are plausible, we will be obliged to look further into the matter of therapists' attitudes.

Thus, in a series of empirical pilot studies (see Dasberg, 1992) conducted by students of the Elie Wiesel Chair for the Study of the Psychosocial Sequelae of the Holocaust, the therapists' readiness to deal with trauma was explored.

Sixteen therapists — MD's, PhD's and SW's — in an academic mental health clinic said, by and

large, that they had no time for so much of this complicated work. Moreover, they said it would be too risky to re-expose people to well-sealed-off traumas, or that they were, of course, ready in principle to deal with those patients, but that at this point there was not a real abundance of these cases.

Another academic mental health clinic was investigated which had about 100 referrals a month, about 30% of whom had experienced traumatic events or loss during the last two years (Brom, et al, 1992), but whose staff did not ask for this information in a systematic manner. Thus, they did not know anything, nor did they recognize posttraumatic signs and symptoms.

Psychotherapists born in Israel after 1945 and in private practice do not always make enquiries about the Holocaust past of their patients, or they even reject its relevancy in relation to the current problems, or wait, with a laissez-faire attitude (Dasberg, 1992).

For those readers acquainted with the historical research of Dina Porat or of Tom Segev on resistances of the Israeli society, these disclosures will not come as a surprise. The negation in this country was, and among some people, especially therapists, still is, massive. The same Israeli therapists, however, had an entirely different attitude towards the Israeli combat trauma in which members of their own generation were involved.

Similar results were obtained from interviews with eight nurses from a kibbutz where, as it happens, many Holocaust survivors reside, and from most of twenty social workers in Beersheba, who claimed that they had not gotten the proper training for Survivors' problems.

In contrast, therapists working within the framework of AMCHA, a national self-help organization for psychosocial and therapeutic support to Survivors, felt that they were "born therapists" and could empathize, and do not hesitate to seek out the trauma.

Personal experience with group supervision of similar groups of therapists of AMCHA certainly allows me to confirm these findings. They work within the framework of an affirming and supportive institute specializing in trauma.

It seems to me that the problem of the therapists' personal part in traumatization or their re-traumatization, and its related working-through of aggression, is a problem not easily solved by all therapists. In addition, I myself could not entirely cope with this in my first case, described above, of a very acute war trauma, but was quite able to do so in the second case of

the child survivor. It seems that therapists who work primarily in the specialized support framework of trauma institutes and/or therapists with a specific trauma background, if at least partly overcome, seem to be able to cope with some of the specific demands of trauma therapy.

Dr. Jucovy, the main author of the well-known book on the Second Generation, said in another recent article on psychoanalytic contributions to holocaust studies:

It is considered especially important for mental health professionals who have suffered *no* direct and personal losses, to inoculate themselves with at least a homeopathic dose of the traumatic experiences and to feel the pain and the loss of dignity and humanity, as so many others did.

From my own experience with trauma therapy, however, I must emphasize that we deal here with quantities that are massive and toxic, and not merely homeopathic.

Conclusion

Post-trauma therapists deal with the problem of "infection" by trauma. Too much co- and re-traumatization of the therapist is paralyzing, but, on the other hand, defensive warding-off of empathic nearness may prevent any therapeutic move from occurring at all. It is a razor's edge.

The therapist, as society's representative, is inclined to take a countertransferential role, to take over the patient's symptoms by identification, or reject the patient. To be aware of these pitfalls is not enough. Trauma therapists have to make an active move, seek out the hidden trauma, and be ready to be emotionally moved, that is, to be open for mutual influence and change.

The immediacy of response has a greater priority in (*post*-)traumatic therapy than in usual psychotherapy. The experience of nearness to the post-trauma patient calls for spontaneity, flexibility, inventiveness, daring and use of a variety of different techniques.

During post-traumatic therapy, it is not only the patient who is facing life and death issues; the therapist him/her self comes face-to-face with the limits of his/her own existence, as has been demonstrated in the present paper, and as was also taught by Robert Lifton (1979). Lifton pointed out the necessity of shifting our theoretical paradigms towards a model of "death and continuity of life" when facing victims of holocausts.

What has been described in the present paper is a form of expressive supportive therapy with an existentialist orientation. Because of their nearness to the trauma, the therapists have special needs too. They need a supportive milieu of mutual support and supervision. Therefore, administrators and clinical policymakers must know that post-trauma therapists need a treatment center in which they can meet and support each other. Mutual trust is the important guiding principle.

In my opinion, trauma treatment in our country cannot be left in the hands of the general mental health services. Nothing will come of it, because the posttraumatic impact on the few scattered therapists who are interested may be too much to bear in isolation, unless better training is provided. However, this topic, for the moment, exceeds the present confines of this paper.

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