

# A Dialogue Between Theories: Understanding Trauma in Helping Professionals

par

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## RÉSUMÉ

Cet article propose une analyse critique des différents concepts présents dans la littérature rendant compte des expériences traumatiques vécues par les travailleurs sociaux, expériences liées au travail de relation d'aide. À la lumière des multiples concepts disponibles, dont notamment le concept de stress post-traumatique, l'auteure suggère d'employer plutôt la notion d'*empathic trauma* pour comprendre et analyser cette question.

## MOTS CLEFS :

Stress post-traumatique, travail social, relation d'aide, traumatisme empathique, fatigue de compassion

## BACKGROUND

My research interest lies in how social workers are impacted by trauma within helping relationships. Through ten years in clinical social work practice I experienced first-hand how social workers are exposed to other people's experiences of trauma in the routine practice of their profession (Bride, 2007). This harm may be an unavoidable by-product of helping relationships (Pearlman & Saakvitne, 1995) and has received burgeoning attention in professional literature (Bride, 2004).

I felt distress following exposure to the painful experiences of clients and their families and challenging interpersonal and systemic interactions. Despite this routine exposure to difficult circumstances, I was given no routine support to manage my distress. Within personal psychoanalytic psychotherapy, I questioned if my challenges as a social worker were due to my own past personal traumas. While it became clear that my history somehow mediated these new experiences, it was also clear that these experiences were deeply disturbing.

In addition to the painful circumstances my clients were living and challenging inter-professional dynamics, my social work department was also under pressure. For example, technological practices, such as workload measurement software, were being gradually implemented. Intended to create accountability and fiscal responsibility, such strategies were often effected

through practices, which ran counter to social work values. Enacting these policy shifts in my role as a professional could only be described as deeply personally traumatizing. For example, I was forced to refuse a bus pass to a man suffering from chronic paranoid schizophrenia, and move a woman suffering from bi-polar affective disorder from her beloved foster home due to changes in budget allocation. In these examples it was not just the suffering of the client that I absorbed. I was personally forced to set in motion the traumatizing events through which I would then accompany my clients.

It felt strange to be positioned as a professional meant to help people with their problems while myself and my profession were rife with our own. This paradox brought me to the discourse addressing the traumatization of workers by client material as a potential source of explanation and healing.

What follows is a critical analysis of the concepts that evolved to explain and empirically study this type of traumatic experience as applied to social work practice. Guided by the question, *What are the main theoretical concepts that have guided the study of empathic trauma in social work?* Through my answer to this question I will offer a working definition of the concept of trauma and outline how the psychological sequel of trauma has been approached in the Euro-western context. The dominant concepts describing the potentially harmful consequences of professional relationships with traumatized people will be presented and the usefulness of these concepts will be discussed in light of recent changes to the posttraumatic stress disorder (PTSD) criteria within the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (APA, 2013a).

## INTRODUCTION

Multiple concepts have been used to theorize and study the potentially harmful effects of helping traumatized people on workers. The contribution of these concepts can be seen in recent changes to the posttraumatic stress disorder (PTSD) criteria within the DSM-5 (APA, 2013a). The criteria for PTSD have been expanded to include workers' exposure to the trauma of those they are serving. In order to differentiate PTSD provoked by vicarious exposure from primary or first-hand exposure, I will here adopt original terminology. Exposure to the traumatic experiences of others will be called "empathic trauma". I am not positing that this term should be adopted beyond the scope of this paper. However, without the use of new nomenclature, my exploration would be incorporating the assumptions of existing scholarship that have emerged from the historical ways we have allowed ourselves to think about trauma in the Euro-western world. I am attempting to explore this phenomenon from a metaperspective that allows for the inclusion of the dominant yet differing concepts that preceded recent changes to the PTSD diagnosis.

### What is Trauma?

The word 'trauma' is not clearly defined (Courtois & Ford, 2009; Weathers & Keane, 2007). Its multiple meanings include "medical/physical injury or psychological injury, as well as the events that cause this injury" (Courtois & Ford, 2009 : 14). While physical trauma may be comorbid to, or cause psychological trauma, my focus will be on psychological trauma. Psychological trauma may also manifest physiologically, through bodily sensations for example, thus any exploration of psychological trauma must consider how traumatic experiences may be embodied. Beyond its multiple meanings, trauma has been defined in multiple ways within the health and social sciences literature (Calhoun & Tedeschi, 2006; Colman, 2012; Janoff-Bulman, 1992; Pearlman & Saakvitne, 1995; Russell, 1991; Scaer, 2005).

A widely accepted contemporary perspective on how to understand psychological trauma can be found in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013a). While the DSM does not offer a clear definition of trauma, its publisher, the American Psychological Association, does:

an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives (APA, 2013b, para. 1).

Notably absent from this definition are "terrible events", which are not located in one moment in time, such as the impact of experiences of long-term childhood abuse or neglect on adults. Even more complex experiences such as individuals or groups experiencing systemic abuse and subsequent poverty or social problems over generations are missing from this definition. Experiences of trauma are very complex and potential sources of trauma are multiple. Looking to the troubled history that Euro-western society has had with addressing psychological trauma may provide greater

insight into contemporary challenges in its definition. The following section will present that history and how it led up to the concepts addressing empathic trauma.

### **Retracing the Euro-western Concept of Trauma: a precursor to empathic trauma**

It was not long ago that psychological trauma was formally acknowledged. Interest in its study, and the development of treatment models for those affected, has since repeatedly stopped and started. Historical events, politics, sexism and patriarchy have all contributed to the inability of society to see beyond existing socio-cultural norms that marginalized people's suffering (Solomon, 1995). Unconscious defenses stemming "from a fundamental human difficulty in comprehending and acknowledging our own vulnerability" (Herman, 1992; Solomon, 1995 : 280), and the conflicting self-interests of individuals and groups directly involved in abusive relationships have also conspired to obscure the work of addressing trauma (Stanton, 1997). This history will begin with the term Hysteria, as it was an early name given to describe how traumatized people present.

### **Hysteria**

Originating in ancient Egypt, a condition called "Hysteria" can be traced from the Greco-Roman period to the mid-20<sup>th</sup> century (Veith, 1965). While the term endured across time, place and culture, its meaning shifted, taking on the ethos of whatever situation within which it was employed (Veith, 1965). The only constant characteristics of Hysteria, until the late 19<sup>th</sup> century, were that it was used to describe women and their "mental disorder". Showalter (1987) situated the construction of the term within patriarchal understandings of women's experiences. She asserted that it was a tool to describe women as fundamentally inadequate. She elaborated how its use betrayed a blindness to the powerful political context of women's oppression and modes of expression. Further, Showalter asserted that madness itself has been metaphorically and symbolically represented as feminine in western culture. Where gendered understandings of madness were constructed making women biologically prone to "Hysteria," men were unfeeling brutes, morally deficient, or "highly civilized" yet stricken with "intellectual and economic pressures" (Showalter, 1995 : 7). Thus, the dominant understanding of the causes of madness were believed to be weaknesses inherent in the individual, unless you were considered to be a "highly civilized man", in which case your madness was assumed to have been triggered by insurmountable external pressures.

### **Hysteria, Psychiatry and Psychoanalysis**

At the end of the 18<sup>th</sup> century, Philippe Pinel was instituting a novel treatment of madness for both men and women at the Salpêtrière Hospital in France. Contrary to prevailing beliefs he was approaching the "insane" from the standpoint that they were treatable (van der Kolk, McFarlane, & Weisaeth, 1996). By 1859, French psychiatrist Briquet identified the maltreatment of children by parents, or wives by husbands as the number one predisposing factor of Hysteria (Briquet, 1859). He also stated that Hysteria could be suffered by men, at a rate of 20 times less than that in women (Briquet, 1859 : 116). Later in the century ongoing work at the Salpêtrière by Charcot inspired Janet, Freud and Breuer further decoupling Hysteria from a woman's sex by discussing the condition as being provoked by traumatic experiences (Akhtar, 2009; Jones, 1953).

Freud repudiated this theory within a year of its publication attributing Hysteria to intrapsychic origins (Akhtar, 2009; Jones, 1953). According to Freud, Hysteria was no longer caused by sexual assault, abuse and incest or premature sexual experiences (Van der Kolk et al., 1996). Some have theorized that this ideological about-face was based in denial. "Hysteria was so common among women that if his patients' stories were true, and if his theory were correct, he would be forced to conclude that what he called "perverted acts against children" were endemic. This idea was simply unacceptable. It was beyond credibility" (Herman, 1992 : 14). While Freud's motivation to change his theory will likely never be fully understood, his contemporaries who maintained the theory lived to see their works neglected and forgotten (Herman, 1992 : 18).

## **Soldiers Affected by War**

As psychoanalytic theorists changed, developed and worked with notions of Hysteria for decades, psychiatry only renewed its interest in trauma in the early 1900s as soldiers returned from World War One (1914-1918) (Pryce, Shackelford, & Pryce, 2007). Although men were still considered incapable of Hysteria, its symptoms were evident in “shell-shocked” soldiers. Thus, traumatized soldiers were considered insane, moral invalids, cowards, or lacking in discipline or loyalty unless a physical cause of their symptoms, such as blood toxicity or “excessive action of the lachrymal glands,” could be ascribed (Showalter, 1987 : 170). And, as Hysterical women before them, many male veterans were treated with the use of techniques that by today’s standards could only be described as torture, for example.

Concurrently, in the United States, Abraham Kardiner, the anthropologist and psychoanalyst, was working on his ground-breaking book “The Traumatic Neurosis of War” (1941). This work later set the stage for how posttraumatic stress disorder would be formulated (van der Kolk et al., 1996). Whether due to the irreconcilable nature of men exhibiting Hysterical symptoms, or the avoidance of including a soldier’s psychological health in the costs of war, interest in the suffering of veterans was short-lived (McFarlane & de Girolamo, 1996). The Second World (1939-1945) and Korean (1950-1953) Wars (Pryce et al., 2007) again briefly brought the suffering of soldiers to the fore, but it was not until the Vietnam War (1955-1975) that interest did not dissipate once the war ended.

## **Vietnam Veterans and Feminists**

Unique to the post-Vietnam period in the United States of America, a growing group of psychiatrists was offering services influenced by earlier work on trauma (van der Kolk, McFarlane, & Weisæth, 2007). A grassroots movement of soldiers started self-help groups and invited professionals to aid them in their struggle to readjust following their service (Pryce et al., 2007). Parallel to this, the women’s liberation movement was challenging patriarchal ideals, including accepted Freudian theory, and drawing focus to the needs of traumatized women and children (Pryce et al., 2007). Prior to feminism, mainstream trauma study of the time was almost exclusively centred on white males (Pryce et al., 2007). With this expanded field of vision, vulnerable emotions in men could be seen as less pathologizing and female sexual assault survivors could be identified as having similar symptoms to those exhibited by veterans (Kimerling, Ouimette, & Wolfe, 2002). In response to the groundswell of people presenting for treatment in the wake of trauma, the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) articulated PTSD for the first time (APA, 1980). In this same volume, and for the first time, Hysteria was referred to as a “previous” name used for a variety of diagnostic concepts, which had now been “modified” rendering them formally obsolete (APA, 1980 : 371). Formalizing PTSD as a recognized and legitimate medical diagnosis brought the idea of trauma and its psychological sequel into the general consciousness. It also created a scientific and legal basis for addressing experiences of trauma, which for the first time in known history treated men and women similarly.

## **Violence Against Women and Children**

In the 1980s, it was still considered radical for women to speak openly about sexual assault, conjugal violence, childhood sexual abuse, or gender-based exploitation (Herman, 1992; Pryce et al., 2007). Those who did were met with “ridicule, humiliation, disbelief” (Herman, 1992). Despite powerful social denial and dismissal, feminist artists, writers and scholars placed a focus on personal traumas as products of Euro-western patriarchy and its tools of oppression (Herman, 1992; Hooks, 1981, 1984; Lorde, 1984). Personal narratives concerning violence against women and children emerged in public, breaking the societal taboos and allowing more victims to step forward and seek help (Herman, 1992).

The number of grassroots organizations grew in response to the needs of women and children who were now visible as millions affected by interpersonal abuse (van der Kolk et al., 1996). In 1988 Charles Figley launched the “Journal of Traumatic Stress” defining traumatic stress as a field of study for the first time (Figley, 1988); and, the discussion of child sexual abuse was galvanized that same year with the publication of “The Courage to Heal: a Guide for Women Survivors of Child Sexual Abuse” by Ellen Bass and Laura Davis. This best-seller offered a detailed guide for women survivors of child sexual abuse and broached what would become a very controversial subject in the history of traumatology: memory.

## **Memory**

The psychological process of memory was not yet well understood by psychiatry or the psychoanalytic community. Despite this, it was clear to both groups that traumatic experiences changed how memory operated. While understandings of memory were in their infancy, qualitative accounts poured forth from abuse survivors about their experiences of memory in the aftermath of trauma.

It was through such accounts that Bass and Davis discussed the nature of memory and healing in their book. They acknowledged that memories might never be accessed or remain unavailable without the person’s use certain of techniques. They also urged women who felt that something had happened, without concrete memory of it, to treat their symptoms, regardless of any proof of abuse (Bass & Davis, 1988).

This clinical perspective joined a highly controversial, international public discussion around “repressed memories” that had been going on since the publication of the best-seller “Michelle Remembers” (Pazder & Smith, 1980). Psychoanalytic thought of the time considered that traumatic memories were defensively pushed out of consciousness (McWilliams, 2011). “Michelle Remembers” (1980) claimed to tell the true story of widespread Satanic ritual abuse of children in North America. Describing one girl’s account to her therapist, it became fodder within the popular media throughout the 1980s and into the 1990s. There was a resulting climate of public fervour between claims of widespread occult violence and the emergence of the victims of sexual and physical abuse. It was during this era that the field of traumatology was formalized (Donovan, 1991). It was also when one cognitive researcher and university psychologist approached her parents regarding her own childhood abuse and spurred events that would obfuscate the voices of victims and challenge what types of treatment they could receive from professionals.

## **Memory and Violence Against Women and Children**

In the early 1990s, Dr. Jennifer J. Freyd, a Stanford University trained psychologist, recovered memories of childhood sexual abuse by her father (Stanton, 1997). This occurred within psychotherapy that she had engaged in regarding other concerns; she approached her parents to discuss what had happened. Their reaction to her disclosure resulted in a chain of events that manifested the powerful social denial and divides at play in facing abuse related trauma. Her parents responded to her by founding the False Memory Syndrome Foundation (FMSF) in 1992. This foundation shifted public discussion about abuse away from its victims. The FMSF claimed the parents and grandparents named as perpetrators were actually being victimized by therapists who had implanted false memories into the alleged victims who had sought out their services (Stanton, 1997).

Traumatic amnesia had been documented for well over a century (van der Kolk et al., 1996 : 37); however, science was still unable to substantiate how memory operated in relation to trauma. Concurrently, high-profile examples, such as “Michelle Remembers”, were in the process of being publicly discredited. The FMSF used such rare and extreme cases to suggest that the phenomenon of

recovered memory was more likely the production of “false memories”. Healing professionals differed on best practices for the treatment of trauma and the FMSF worked against many therapists and writers by suing, or attempting to discredit them. In some cases they succeeded in changing laws in an effort to end all practices that they deemed capable of generating “false memories” (Stanton, 1997; van der Kolk et al., 2007). The memory debates fit well within and widened pre-existing rifts between positivist and post-positivist scientific approaches as the validity of differing research methods collided within Traumatology (Baldwin, 1997). Gender stereotypes of women as Hysterical or unreliable persisted (Herman, 1992); and ironically, these stereotypes fit well with the characteristically impaired ability of trauma survivors to coherently recount experiences of trauma (Herman, 1992).

However, it was now undeniable that PTSD was not intrapsychic in origin or due solely to natural disasters and accidents. Brutal or unethical treatment was also responsible for psychological disorder. Those who abused others had become visible through a strong faction of the traditionally exploited who had empowered themselves. Resulting perspectives on violence and abuse weakened accepted views that focused on traumatized people as the problem. This enabled victims to speak out, and posed potential social, legal and financial consequences for all parties perpetrating abuse (Herman, 1992).

The horrors of child abuse, war, sexual assault and conjugal violence provoked powerful affects as they emerged into general consciousness. Professionals, institutions and large parts of society continued to stigmatize and blame victims as their realities were too painful to bear (van der Kolk & McFarlane, 1996). Defenses such as “repression, dissociation, and denial (were a) phenomena of social as well as individual consciousness” (Herman, 1992 : 9). In an effort to discredit them, allies of the abused were also treated as liars, malingerers or morally flawed (Herman, 1992; van der Kolk et al., 2007).

Despite the battle raging on, major advances had been gained. The general question of what memory was and how it operated had been expanded. Traumatic memories in particular were now understood to operate in particular ways and memory retrieval practices were ceased in therapy with trauma survivors.

### **Emerging Understandings**

Many scholars and clinicians were now interested and working to understand trauma, affect and relational processes. Examples will be explored here that have particular relevance for how empathic trauma later came to be understood. Two psychoanalytic ideas that offer some insight into how trauma would later be formulated are countertransference and projective identification. These theoretical constructs addressed how emotions and experiences could be unconsciously shared between the analysed and analyst.

Freud called the phenomenon of being psychologically affected by one’s patient “countertransference”. He believed it to be a threat to objectivity requiring mastery, control or elimination (Dalenberg, 2000 : 5). Several schools of thought have emerged to discuss this phenomenon rendering the larger discourse of countertransference beyond the scope of this paper (Dalenberg, 2000; Davies & Frawley, 1992). The perspective adopted here is a “totalistic view” in that countertransference can be described as “all of the therapist’s feelings and emotion-related behaviour toward the client” ( Dalenberg, 2000 : 10). These feelings and behaviours are data that can be explored not only as reactions to the here-and-now in therapy, but as evidence of how the client constructs relationships based on their past. Feelings and emotion-related behaviour thus become clues as to the clients’ internal working models of the world as the therapist participates *with* the client (Rasmussen, 2005).

Another key concept, introduced by psychoanalyst Melanie Klein, is projective identification (1946). Klein described how patients projected their affect into their therapists. While a full discussion

of this concept is also beyond the scope of this paper, my position is in line with recent intersubjective theorizing that has rejected projective identification as a phenomenon (Stolorow, Atwood, & Orange, 2002). That therapists come to feel and sometimes think as their clients do during the therapeutic process is not disputed. Rather, the process by which this happens has been challenged. While the exact process is still unclear, Stolorow, Orange, and Atwood (1998) cite recent infant observation research showing that the affective states of people on videotape were transmitted to infants who were shown the tapes (Davidson, 1982). Debunking the notion that unconscious intent is the cause of the transmission of affect and suggesting instead that unconscious and non-verbal communication enables affective atonement.

The seeming transfer of experience was also explored in the late 1800s when psychoanalytic theorists looked at the “impact of parents' neuroses on their children” (Portney, 2003 : 1); but, it wasn't until after World War II that the intergenerational transmission of trauma was identified through empirical research with the children of holocaust survivors (Portney, 2003). Initially these children were seen to bear similar symptoms as their parents or even suffer a unique psychopathology (2003). Solomon, Kotler, and Mikulincer (1988) discovered that certain children of holocaust survivors had an increased risk of suffering PTSD. The intergenerational transmission of trauma has since been identified in other groups, particularly Aboriginal populations who have suffered the traumatic impacts of colonialism both through their own experience and that of their families and communities (Kirmayer, Simpson, & Cargo, 2003).

Finally, in the late 1980s, scholarship emerged that discussed affective states and trauma as contagious (Eth, Silverstein, & Pynoos, 1985). Mollica (1988) suggested that therapists became “infected” with their clients' hopelessness and Courtois (1988) discussed “contact victimization” cautioning that PTSD could be caught. Hatfield, Cacioppo & Rapson (1994) published “Emotional Contagion” building on this perspective by asserting that all emotions were contagious.

By 2002, however, infant observation research demonstrated how affective states between mothers and their babies became attuned through non-verbal, unconscious communication (Rothschild, 2006; Stolorow et al., 2002). Replacing contagion with affective atonement in reference to the process by which we come to *feel with* or *as* others. Through such processes, helping professionals came to be understood as personally drawn into the experiences of their clients. This was reflected in the DSM-III (APA, 1980) and further elaborated in the DSM-III-TR (APA, 1987) where PTSD was described as potentially provoked by merely being close to others affected by trauma.

In his exploration of “secondary victimization” Figley (1988) brought to light the impact of trauma on family members. McCann and Pearlman (1990) employed this same notion in the therapy room introducing the stress reactions of trauma counsellors in “Vicarious traumatization: A Framework for Understanding the Psychological Effects of Working with Victims”. Here the Constructivist Self-Development Theory (CSDT) of trauma (McCann, Sakheim, & Abrahamson, 1988a) was applied to address the deleterious effects of helping traumatized people on the helping professional. Empirical evidence quickly amassed, confirming potential negative impacts of treating traumatized people on therapists (Munroe, 1990; Pearlman & MacJan, 1995).

Concurrently some psychoanalytically informed scholars were exploring the topic as “traumatic countertransference” (Herman, 1992). In reference to treating adult survivors of childhood sexual abuse Davies and Frawley (1992) wrote:

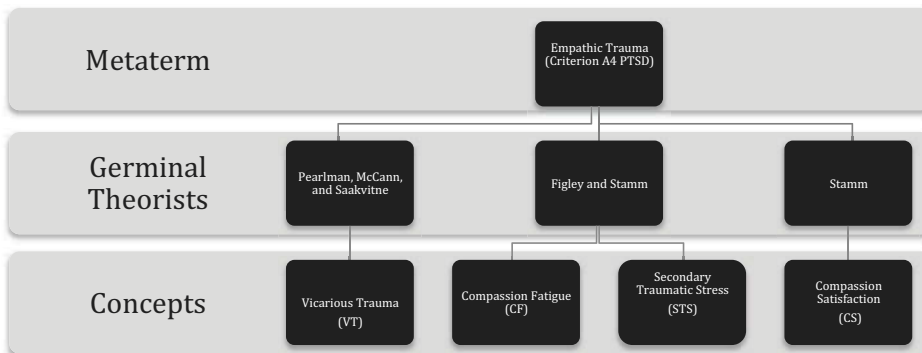
The patient must recognize and come to terms with the finality and irreversibility of the traumatic loss. This is a long and arduous process of working through intense rage and profound pain. Every resistance possible will be called up by the patient to avoid this mourning process, and the analyst will inevitably be swept up into a maddening conundrum of elusively shifting transference-countertransference enactments. (Davies and Frawley, 1992 : 26).

## Dominant Theories of Empathic Trauma Prior to 2013

Over the next twenty years interest in the potential for professionals to suffer negative impacts from their clinical work with traumatized people exploded. By 2010 a comprehensive bibliography of work-related trauma that spanned disciplines contained 1,034 citations (Stamm, 2010, November). The names given to explore empathic trauma in social work were: secondary traumatic stress (Figley, 1995), compassion fatigue (Figley, 1995; Stamm, 1995) and vicarious traumatization (McCann & Pearlman, 1990c; Stamm, 1995). Since the elaboration of these concepts, significant findings have emerged applying each through empirical research.

Workers exposed to trauma have been shown to have altered clinical judgment, even when standardized practices are used (Regehr, LeBlanc, Shlonsky, & Bogo, 2010). Bride (2007) found that social workers suffer from post-traumatic stress disorder at twice the rate of the general population and posits that this is due to secondary exposure to trauma. Such research elaborated that workers exposed to the trauma material of others were at risk of suffering “potentially profound effect(s)” (Rasmussen, 2005 : 19). The scholars who first elaborated these concepts were directly involved with trauma through clinical and humanitarian work. Informed by first-hand experience, they made the first attempts to describe what we can now call PTSD as provoked by “repeated or extreme exposure to aversive details of the traumatic event(s)” (Criterion A4, PTSD). The following three sections will elaborate these germinal concepts (represented in Figure 1, below).

**Figure 1 Theories of Empathic Trauma**



### Vicarious Trauma

Vicarious Trauma (VT) was described as a process whereby the therapist’s self was affected over time by exposure to the trauma of their clients. The concept was originated in the landmark paper “Vicarious traumatization: A framework for understanding the psychological effects of working with victims” (McCann & Pearlman, 1990d). Pearlman and Saakvitne furthered this work in tandem with the concept of countertransference through an analysis of dynamics and themes within psychotherapeutic relationships with incest survivors in their book “Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors” (1995). Both works used the lens of Constructivist Self-Development Theory (CSDT) (McCann, Sakheim, & Abrahamson, 1988b), as the foundational framework of the VT concept.

CSDT “suggests that the helpers’ unique VT responses arise from an interaction between the helper and the situation” (McCann & Pearlman, 1990a, 1990b). Originally posited as a theoretical basis from which to understand the effects of trauma on its survivors, the authors applied it as a framework for “understanding the impact of trauma work upon the therapist” (Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995, : 56). Through the integration of psychoanalytic/dynamic theories (object



relations, self psychology, interpersonal psychiatry) and cognitive theories (constructivist thinking, social learning theory, and cognitive developmental theory), this framework seeks to emphasize integration, meaning and adaptation in the wake of trauma. Symptom and stage-focused treatments were rejected as neglecting individual differences, processes and/or strengths. An example of how this theory differs from other models is in how it addresses “symptoms” as adaptive strategies for survival.

Key to CSDT is its definition of trauma and formulation of “pathognomonic responses”:

We define (trauma) as the unique individual experience, associated with an event or enduring conditions, in which (1) the individual’s ability to integrate affective experience is overwhelmed or (2) the individual experiences a threat to life or bodily integrity. The pathognomonic responses are changes in the individual’s (1) frame of reference, or usual way of understanding self or world, including spirituality, (2) capacity to modulate affect and maintain benevolent inner connections with self and others, (3) ability to meet his psychological needs in mature ways, (4) central psychological needs, which are reflected in disrupted cognitive schemas, and (5) memory system, including sensory experience. (Pearlman & Saakvitne, 1995 : 60-61)

VT was defined as “the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients’ trauma material” (Pearlman & Saakvitne, 1995: 31). It was also described as “an occupational hazard, (and) an inevitable effect of trauma work” (Pearlman & Saakvitne, 1995 : 31). Countertransference and VT were described as interacting in a cyclical fashion whereby the therapist could lose self-awareness and become reactive and/or defended within therapeutic relationships. This could then lead to a greater vulnerability to VT (Pearlman & Saakvitne, 1995). Countertransference contributing to “therapeutic errors and interpersonal misunderstandings or empathic failures” (:318) in addition to the personal costs of VT on the therapist.

The notion of therapy as a relationship is central to Pearlman and Saakvitne’s (1995) theorizing. They considered that looking only to the client-member of the relationship was insufficient. Further than the dyadic relational context of psychotherapy, Pearlman and Saakvitne considered trauma therapy as a socio-political act. They acknowledged the challenge that trauma presented society and the pivotal role played by those who treated it. Trauma therapy was more than treating survivors, it was to “name and address society’s shame” (:2).

CSDT and VT have developed over time but conceptually have remained largely stable. Attachment theory has been incorporated through both relational treatment for trauma survivors and in considering the attachment styles of the workers themselves (Pearlman & Courtois, 2005). CSDT has expanded to include survivors bodily responses (Pearlman & Caringi, 2009). The helper’s inadequately processed empathic engagement is the “hypothesized mechanism for the development of VT” (Pearlman & Caringi, 2009 : 205).

The concept of VT differs from other conceptualizations of empathic trauma in that it is seen as a process that reaches through the worker and can occur overtime and/or between cases. The focus on the relationship is also unique, excluding later work by Stamm (2013). VT stems from the psychoanalytic theorizing, refusal of the medical model and engagement with the conscious and unconscious world of the worker.

### **Compassion fatigue**

Figley’s edited book “Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized” built upon his previous work addressing trauma as contagious to family, friends or professionals (Stamm, 1999). Here he was addressing this phenomenon that he had previously observed as “secondary victimization” (Figley, 1995; McCubbin & Figley, 1983) in relation to professionals engaged in relationships of care.

Describing the terms 'secondary traumatic stress (STS)' and 'secondary traumatic stress disorder (STSD)' as the "latest and most exact descriptions" of the phenomenon (Figley, 1995, p. 14), he promoted the use of the term 'compassion fatigue (CF)' stating that it was preferred by professionals who found it less derogatory, a better descriptor of their suffering, and more "friendly" (:14). He also developed "the Compassion Fatigue Self-Test for Psychotherapists... to help therapists differentiate between burnout and STS" (Figley, 1999 : 17).

Compassion Fatigue was defined as "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995 : 7). Key in his theorizing was the predisposition to secondary traumatization as a result of caring for traumatized people. Thus, like family members and loved ones who were acknowledged as at risk by the DSM of the time, helping professionals were also vulnerable. "An emotional arousal appears to be associated with an empathic and sympathetic reaction. Also, in the process of dispensing this care, the support becomes exhausted" (Figley, 1995 : 5).

He suggested that several groups were at greater risk for CF: workers who saw themselves as saviours or rescuers, those who have been primary trauma victims themselves, those who have not resolved their own primary trauma and those working with the suffering of children (Figley, 1995). He also stated that by helping the helpers, the primary victims of trauma would be better served.

Inspired by the new diagnosis of PTSD (APA, 1980), Figley approached STS through the metaphor of a psychological disorder and proposed a framework to add Secondary Traumatic Stress Disorder to the next DSM. His diagnostic criteria were based on those for PTSD. He further proposed that PTSD should be replaced by a category that would contain both "Primary Traumatic Stress Disorder" (in lieu of Post Traumatic Stress Disorder) and STSD. While there had yet to be significant empirical data to substantiate the existence of such a disorder, Figley sought to provide a theoretical basis for its assessment and innovative treatment. He took the position that there was a responsibility to warn and protect the next generation of trauma workers of this risk to their well-being.

He explained that PTSD and STSD were the same in every way except for the source of the trauma and resulting symptoms as related to only the self (in the case of PTSD), or the self and the client or loved one (in the case of STSD). Two major concepts were addressed as highly related to STSD: countertransference (CT) and burnout (BO). BO was described as being linked with the inability to meet the needs of the clients you are serving and the pain felt by belonging to a system that stifles empowerment and well-being (Figley, 1995 : 11). He described the differences between BO and STS/CF as BO being a *process* whereas STS/CF could be rapid in its onset, was accompanied with feelings of helplessness, confusion and a sense of isolation from supporters and a lack of connection with the cause of these symptoms. He also claimed STS/CF to have a faster recovery rate (Figley, 1995). No empirical evidence was offered to substantiate these claims.

Figley differentiated STS/CF from other constructs, identified it as a disorder, devised a measure for it (Figley, 1995) and addressed the importance of its treatment and prevention. He sought to reformulate PTSD, reconceptualize trauma such that its impact on individuals, relationships, and systems could be better recognized, to review the scholarly and clinical literature in this new light, and to propose new ways to work given these new understandings. His formulation of empathic trauma then drastically changed and he began adopting an eclectic, at times confusing, use of multiple theories.

In his 2006 work with Boscarino and Adams, Figley asserted that CF was a different concept than STS altogether, one which blended burnout and compassion fatigue (Adams, Boscarino, & Figley, 2006). In the 2007 special issue of the "Clinical Social Work Journal," he stated that "though there are some distinctions between vicarious traumatization and secondary traumatic stress/compassion fatigue in terms of theoretical origin and symptom foci, all three terms refer to the negative impact of clinical work with traumatized clients." While this seems logical, he (Bride, Radey, & Figley, 2007 : 156)

later used VT interchangeably with STS and called CF a more inclusive name that comprised VT and BO (Boscarino, Adams, & Figley, 2010). He did not offer a perspective on how to address contrasting perspectives regarding the medical model, differences in how the unconscious is treated and the use of different research measures across these concepts.

## **Secondary Trauma**

“Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, & Educators” edited B. H. Stamm, Ph.D. was first published in 1995 and in a new edition in 1999. Her original preface revealed her personal inspiration for engaging in trauma work as set apart from her objectivity as a scientist. Stamm described how the notion of trauma challenged her detached scientific stance, connecting deeply with herself. She placed her hope in the face of terrible suffering and seemingly insurmountable problems in the “nurturance of the individual within the sustenance of community” (Stamm, 1995 : 17). Calling upon “teachers, clinicians and researchers” involved in healing mandates to “build strong sustaining communities” (Stamm, 1995 : 17).

In her second edition she explained that she, as Figley, originally looked to PTSD as a template for understanding STS. Later her stance changed, seeing it as “both more and less than the extension of the post-traumatic stress disorder diagnosis” (: 20). She explained that she believed the terms STSD and VT to be “harsh”. She also acknowledged the relationship that counter-transference and burnout had with CF. She problematized the term “self-care” asserting that it placed inappropriate responsibility on the person concerned and did not address the source of the problem, and explained that CF was a term that she helped to develop, but was no longer satisfied with.

Despite her difficulties with the nomenclature of empathic trauma, her interest and research into the area was not deterred. Like Figley, she saw the phenomenon as extending to all people who care for the traumatized, but focused on people who have been exposed to the trauma of others through their work. She also commented on the complexity that arose when the professional facing STS has also suffered primary trauma and the reality that all people are exposed to STS through their loved ones’ experiences (Stamm, 1999).

Regarding the question of STS as a disorder, Stamm ultimately rejected a linear construct of STS leading to STSD or PTSD. She acknowledged that it was one possible outcome of empathic exposure to trauma but believed it was part of complex processes that may also lead to “somatic reactions, dissociation, depression, complex PTSD and substance abuse” (Stamm, 1999 : 20). She saw the individual’s ability to cope as a determining factor in whether or not a stressful event turns traumatic.

She addressed how STS seeped out of the professional life and into the personal, and saw the supports in both personal and professional spheres being key in protecting the professional. She also explained that she had come to see a necessity in understanding what she coined as Compassion Satisfaction (CS). Compassion Satisfaction is Stamm’s unique contribution to the discussion of empathic trauma, it is described as the pleasure that one derives from doing their work (Stamm, 2013). In assessing STS she promoted a comprehensive approach whereby she measured individuals’ personal histories of stressful events, their exposure to secondary trauma, and a measure of quality of life. She was also transparent regarding the value of claims without adequate existing empirical data to substantiate them.

In recent years Stamm has continued her work on Compassion Fatigue and Satisfaction through her website [www.Proquol.org](http://www.Proquol.org). There she provided a comprehensive bibliography, free access to her measures, presentation aids and other resources. She also collects data from those who use her measures and enters it into a large private data bank. She offered this model of CS and CF:

**Figure 2 Professional Quality of Life Model (Stamm, 2013)**



VT is described as something that is related to STS in that both are about being exposed to the trauma material of others, the difference being that VT is provoked by repeated exposure over time. Contrary to Figley, she now sees CF as a descriptive term addressing the quality of a person's experience. Pathology may also be present, but it would be comorbid to CF. Examples such as burnout accompanied by depression or CF accompanied with PTSD are offered.

### **Vague and Unclear**

The germinal empathic trauma scholars drew from their own practice experiences. Pearlman, Figley, Stamm, McCann and Saakvitne were all involved in clinical or humanitarian work, which illuminated the second-hand effects of trauma. It was from these experiences and those which they observed in others that they constructed understandings of this phenomenon and measures to enable its empirical study. The explosion of literature that followed confirmed the relevance of their work.

Adams, Figley, and Boscarino (2008) identified five major limitations in the resulting literature. The first and most widely cited limitation, is the lack of conceptual clarity regarding empathic trauma. Several scholars have addressed the resulting challenges posed to understanding the development, presentation and treatment of empathic trauma (Baird & Kracen, 2006; Meadors, Lamson, Swanson, White, & Sira, 2009; Thomas & Wilson, 2004). Related to this is the confusing nomenclature discussed earlier in this paper. More recently, researchers have further confounded the field by borrowing certain elements from two or more conceptualizations to create eclectic theoretical stances from which to study the phenomenon. Secondly, a large number of scales are in use "employing dissimilar conceptualizations and measurement methods" with unclear psychometric properties and items ill adapted to identify social workers at risk for psychological distress (Adams et al., 2008 : 239). For example, the measures used for STS, CF and BO have been shown to capture different elements of worker experiences and thus not interchangeable (Meadors et al., 2009).

Thirdly, the studies have not used conceptually valid research frameworks, causing a particular problem for the selection of predictor variables. For example, trauma was assumed to be transmitted from person to person through caring or empathy without validated models within which to understand such a process. Several studies have addressed risk and protective factors such as age, gender, exposure levels, academic training, professional role, work specifically with childhood trauma survivors, personal trauma history, or coping and support mechanisms (Bride, 2004;

Buchanan, Anderson, Uhlemann, & Horwitz, 2006; Caringi, 2008; Gottfried, 2011; Kassam-Adams, 1998; Pearlman & MacLan, 1995; Regehr et al., 2010; Regehr, Leslie, & Howe, 2005). However, these attempts to predict traumatization in social workers have not produced convincing evidence to support predisposing variables, save the exposure to trauma itself (Brend, 2013).

The fourth limitation identified by Adams et al. (2008) is that the studies, which have been conducted, have largely not used random sampling, limiting generalizability. The lack of exploration of workers' psychological distress is the fifth and final limitation cited. Little is understood about the impact of this type of traumatization on a worker within or outside of the workplace. Rather, concerns such as the impact on clients or worker retention have been the focus of much of the empathic trauma research.

In addition to the above-mentioned limitations, in general, research and thinking about trauma has changed drastically over the past two decades. Since the emergence of this literature, understandings of memory, empathy and vicarious experiences have further developed, transforming some of the assumptions upon which the original ideas were based. For example, researchers studying the activity of neurons in the brains of monkeys accidentally discovered that there are neurons that activate both when we do an activity and when we see another do the same activity (Gallese, Fadiga, Fogassi, & Rizzolati, 1996; Rizzolati, Fadiga, Gallese, & Fogassi, 1996). In finding that human beings have such "mirror neurons", it is now understood that there is a neurocognitive basis for empathy (Rothschild, 2006). This knowledge was not yet available when STS, CF and VT were conceptualized.

In reviewing the empirical literature applying these concepts there also appears to be a lack of inductive research, and only twenty-four peer reviewed studies looked uniquely at social workers. Of those studies published prior to June 2013, only six employed qualitative methods. This trend is seen at all levels of inquiry. For example, between 1998 and 2013, 87 dissertations addressing these concepts were entered into Dissertation Abstracts, and in the ten studies looking at social work, only two employed qualitative methods.

### **From Theories of Empathic Trauma to PTSD**

Previous conceptualizations of empathic trauma allowed for empirical research concerned with the traumatic experiences of helping professionals and sparked discussion regarding the cost that helpers pay in the line of duty. In the DSM-5 (2013) the APA made a major addition in line with the study of empathic trauma, Criterion A4 for a diagnosis of PTSD:

Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related (APA, 2013a, para. 27)

The DSM is a very widely used tool in North America. Its diagnostic categories are accepted across disciplines (law, business and medicine, for example), and multiple validated measures have been developed based on its formulation of trauma. A definition of trauma derived from the DSM-5 is, "psychological wounding from exposure to actual, threatened, or the aversive details of death, serious injury or sexual violence to oneself, a loved one, or person in one's care" (2013).

Including empathic trauma under the rubric of PTSD stands to radically alter the discussion, research methods and measures used to address workers' trauma. While this formal recognition is an advancement in the field, such a change also creates debate and a "problem" for diagnosis, treatment and research (Weathers & Keane, 2007). For example, PTSD has its own unique set of measures and critiques. One such critique, as discussed in a previous section (pp. 5-6), is that the DSM-5 lacks clarity regarding multiple or repeated traumas. For some researchers and clinicians, this is considered to be problematic. Thus, alternate categories have been proposed to the APA to take such repeated or long-term experiences of trauma into account, but they have not been included in the DSM (Herman, 2009; van der Kolk & Courtois, 2005; van der Kolk et al., 2007).

One example of this is complex PTSD (C-PTSD) (Courtois & Ford, 2009; Herman, 2009), a diagnosis developed to respond to the oftentimes “bewildering” presentations following long-term, repeated and/or poly-traumatization (Herman, 2009). C-PTSD describes symptom presentations, which are not characteristic of PTSD. This is attributed to an etiology of prolonged trauma experienced during vulnerable times in a person’s development resulting in a complex symptom presentation (Courtois & Ford, 2009).

The intergenerational transmission of trauma seen, for example, in Aboriginal Canadians or the children of Holocaust survivors who exhibit symptoms derived from the trauma suffered by their parents (Kirmayer et al., 2003; Portney, 2003) would also not be captured by the DSM-5, nor would the unique suffering faced by workers who are obliged to apply or engage in oppressive policies harmful to the people in their care. The role of adult attachment is also absent from this current conceptualization of trauma, as are the dynamic interplays between multiple traumas, shared trauma (Saakvitne, 2002) and stress-related disorders, when they have occurred to one person. Thus, when adopting the DSM-5 perspective, it is wise to do so critically with the understanding that it is a provisional understanding of trauma, at a point in time when the phenomenon of trauma in general is still evolving.

## CONCLUSION

This paper has traced the development of theories about the impact of professional exposure to the trauma of others within helping relationships. This was done by offering a working definition of the concept of trauma, grounded in how the psychological sequel of trauma has been historically approached in the Euro-western context. The dominant concepts that evolved to describe the potentially harmful consequences of empathic trauma were then summarized, as were critiques emerging from the scholarly literature. Finally, the usefulness of these concepts was discussed in light of recent changes to the posttraumatic stress disorder (PTSD) criteria within the DSM-5 (APA, 2013a).

The concept of trauma has evolved rapidly over the past few hundred years. Human beings who suffered from what we now understand to be PTSD were historically stigmatized and blamed for their symptoms. This shift in understanding, from blaming disordered people for their disorder, to the perspective that traumatic experiences can create wounds sparked a transformation in Euro-western society. This transformation spread from hospitals to battlefields, the public forum to private homes creating social change and hope for groups who had long suffered abuse and oppression.

While light had been cast on this pervasive social problem, the conversation about what it revealed was not easily had. To look at trauma was deeply painful, doing so threatened existing power relations and uncovered the degree of such terrible social realities as child maltreatment and conjugal violence, revealing society’s shame. Cycles and dynamics of abuse had long hid as cultural norms, embedded within the functioning of Euro-western society. There was a powerful backlash against seeing trauma in this new light. The momentum of the legion of survivors and their allies, however, could not be reversed and posttraumatic stress disorder was formalized as a medical condition.

As helping professionals continued to support the healing of traumatized people, new observations surfaced about how working with these populations impacted helping professionals. The idea emerged that through empathic connection with people suffering trauma, *feeling with them*, the effects of the traumatic experiences were also felt. Several scholars sounded the alarm that this empathic trauma was dangerous to both helping professionals and to the clients that they served. Frameworks, theories and measures surfaced as these scholars worked to understand how the destructive force of trauma spread from person to person.

Many different professions joined in the discussion as they too experienced the harmful effects of work-related trauma exposure (Stamm, 2010). The empirical evidence mounted as working with people who experienced trauma exposed workers to personal traumatic suffering. Unlike the birth of PTSD, the formal acknowledgment of empathic trauma came relatively quickly. The APA included work related exposure to trauma into their new criteria for PTSD published in the DSM-5 (2013). While previous concepts describing empathic trauma set the stage for this new definition, a great deal of work has yet to be done to understand trauma in general, and how it impacts helping professionals. The following section will outline implications for future work derived from this history.

## **IMPLICATIONS**

The ways in which traumatized people have been historically viewed and treated reveals several considerations important for future study and treatment. I have identified three broad themes that I propose be considered both in future treatment and research approaches: challenging existing myths, welcoming complexity and seeking broader insights about basic or dominant assumptions regarding trauma.

History is rife with examples of the effects of trauma being attributed to individual flaws or weaknesses. It is necessary to be sensitized to a historical perspective as Euro-western culture still carries within it messages from the past describing traumatized people as hysterical, cowardly, weak or liars. People's individual characteristics such as gender, age or 'race' have had a particular relationship with how abuse and exploitation has been operationalized (Herman, 1992; Showalter, 1987). Enduring stereotypes of affected men as weak, or women as hysterical, are examples of powerful relics that continue to inform views of people suffering from PTSD. While there may be predisposing factors that contribute to the expression of traumatic stress, the clinician and researcher must always be circumspect of explanations that attribute PTSD to individual factors. Researchers and clinicians must be proactive in questioning whether old and erroneous ideas may have infiltrated their work. Uncritical trauma work threatens to collude with pre-existing, tacit, culturally-based power dynamics promoting oppression and shame, creating and silencing victims (Løvseth & Aasland, 2010).

Perhaps due to the painful nature of addressing trauma, the complexity inherent in experiences of trauma may not always be apparent in its treatment or study. For example, PTSD does not address the impacts of long-term abuse. The empirical study of empathic trauma in social workers largely focuses on work-derived trauma rather than considering workers as people with a potential spectrum of traumatic experience - across the lifespan and occurring in different domains of life (Brend, 2013). Looking for potential complexity in people's experiences of trauma may yield new understandings or serve to uncover people suffering in a more nuanced way. An openness to multiple sites of trauma, such as home, work, or community may also bring a more detailed portrait of traumatic experiences. The workplace and its policies are also a neglected potential source of traumatization that warrant attention in the assessment of workers' trauma. A final example of how openness to complexity may prove helpful in treatment and research can be seen in how these experiences are mediated by social location. Gender, 'race', socioeconomic status, and geographical location are all examples of social locations that inform how trauma may be suffered or interpreted. Critically considering these individual factors and how they intersect would offer richness and depth to future treatment and research.

The final implication that I will offer is a suggestion towards more inclusive understandings of trauma. Researchers and clinicians are well served by humility. As history has shown, even deeply and long-held beliefs can be rendered obsolete as new understandings emerge. Future work that considers current definitions as tentative could allow for the inclusion of other perspectives that may be useful in addressing trauma. Several interesting concepts have emerged that resonate within the

field, such as intergenerational trauma or complex trauma. While these ideas are not part of the formal definition of PTSD, they have been instrumental in emerging discussions regarding particular phenomena and experiences. Also, while this paper has focussed exclusively on the Euro-western context, informing and challenging dominant understandings of trauma can only add to the richness needed to understand each other's experiences and in the continued effort to hone a shared definition. Western thinking about trauma has been critiqued as too individualistic, rigid and disrespectful to other cultural perspectives (Dubrow & Nader, 1999). Thus, an active exploration of different concepts, models or metaphors of trauma emanating from our clients and participants, our colleagues in other parts of the world, different cultures or religions, for example, may enrich and inspire future work.

We are only beginning to understand the pervasiveness of trauma in the lives of people who are helpers. Validation that social workers are truly at risk is a momentous first step. We must now listen to the voices of those who have lived these experiences in order to understand the complex factors at play when trauma spreads from its victims to their helpers.

## SUMMARY

This article presents a critical analysis of various concepts found in literature regarding the traumatic experiences of social workers — experiences linked to their work as helping professionals. In light of the many concepts available, notably that of post-traumatic stress, the author recommends the use of the *empathic trauma* notion for understanding and analysing this issue.

## KEY WORDS:

Post-traumatic stress, social work, helping relationship, empathic trauma, compassion fatigue

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