Introduction to

Trauma and Countertrauma, Resilience and Counterresilience

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An Evolution of Ideas

In the spring of 2012, I was invited by the William Alanson White Psychoanalytic Society to give a paper the following year as part of a colloquium series entitled "More Simply Human…" The title took its inspiration from Harry Stack Sullivan's famous quote "We are all much more simply human than otherwise" (Sullivan, 1966, p. 7). I was asked to speak about any topic that currently interested me.

As it happens, feeling unusually weary, I had recently taken stock of my practice. In the years since the 1980s my work increasingly focused on working with men with histories of boyhood or adult sexual abuse or assault. My 1999 book *Betrayed as Boys: Psychodynamic Treatment of Sexually Abused Men* (Gartner, 1999) remains one of the few resources for professionals on this topic, and my 2005 book *Beyond Betrayal: Taking Charge of Your Life after Boyhood Sexual Abuse* has become a valuable resource for lay people struggling to understand the aftereffects of boyhood sexual abuse on themselves or on their partners or loved ones. Men seeking help had only to look on the Internet to

find my name when seeking a professional with experience in this area, and so the Internet itself became a major referral source to my practice of men with histories of sexual victimization.

As I considered my schedule, however, I realized there had recently been an upsurge in the number of men calling, writing, or coming for initial consultations. Looking through my records, I discovered that in the two months following the November 2011 revelations of sexual abuse by coach Jerry Sandusky at Penn State University, I had more initial consultations with sexually abused men than I usually have in a year. Others wrote or called, but never came in to see me. I was hearing far more stories about childhood trauma in concentrated periods of time than ever before. Tragedy after tragedy was added to the ugly tales already residing in my consciousness and unconsciousness. It was taking a toll on me.

I decided this was the area that interested me most, and determined to write about it for the White Society Colloquium. The paper I produced is the basis for Chapter 1 in this book, and indeed is the inspiration for the book.

I chose to focus through an experience-near approach on my ongoing feelings during the treatment of a single man, with reference to a few other men I have treated. The man on whom I focused, whom I call Duncan, had presented unusually difficult and challenging traumatic material that unfolded over the course of years of treatment, and I sensed I had many painful feelings about the treatment just beneath my consciousness.

I wanted to be as frank as I could about my internal reactions as I worked with Duncan. But as I wrote, I discovered I had opened an internal Pandora's box of emotions.

As I translated my inchoate feelings into a descriptive verbal narrative, I found I had more and more to say, and I felt more and more overwhelmed by what I was saying. I finished a draft and hastily put it away about six months before I was to present the paper.

Two months before the presentation, I re-opened the paper while on an airplane, and re-read it. Absorbing the extent of Duncan's trauma and tragedy as I read my own words, I was forced to face the extent of my reactions to him and to our work. I felt paralyzed and found tears rolling down my cheeks and a lump in my throat. I stared at my computer screen and thought, "I can't possibly read this paper out loud. I will never make it through without breaking down. I won't just be unable to speak further, but I will start to sob and not be able to stop sobbing and finish the paper. I will embarrass myself and demonstrate my inability to maintain a proper emotional distance from my work."

Almost immediately, however, it occurred to me that these shattering feelings were exactly why I wrote the paper and why I should present it. I was certainly not alone in my reactions to trauma work. Perhaps it would help other clinicians - especially those less experienced than I - to hear about my work's effects on me. For reasons discussed below, I call these cumulative effects countertrauma, with a companion concept of counterresilience referring to the positive impact trauma work can have on the treating therapist or analyst.

The underlying concepts for countertrauma and counterresilience are, of course, psychological trauma and psychological resilience. I have elsewhere described psychological trauma as "a reaction to an overwhelming life experience. Traumatic events are unexpected, unusual, often coming without warning, exceeding a person's

capacity to deal with them and seriously disrupting his or her psychological stability and frame of reference" (Gartner, 1999, p. 15). Psychological trauma has been widely studied by researchers and clinicians in recent years. While the literature is too vast to summarize here, I note the contributions to it from many of the authors in this volume (e.g., Bloom, 1994; Courtois, 2010; Gold, 2000; Howell & Itzkowitz, in press; Pearlman & Saakvitne, 1995).

Psychological resilience, on the other hand, is an adaptive response to psychologically traumatic events, "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress" (American Psychological Association, undated). It is often seen as a crucial factor in the ability to recover from psychological trauma (Fletcher and Sarkar, 2013; see also Deveson, 2003; Seligman, et al., 1995; Southwick and Charney, 2012; Wicks, 2010). But perhaps the richest and simplest explanation of psychological resilience is in the words of Elisabeth Lukas, a protégée of Viktor Frankl who may have been quoting him: "The forces of fate that bear down on man and threaten to break him also have the capacity to ennoble him" (as cited by Southwick and Charney, 2012).

Nearly all of our patients were traumatized in some way. We hear about the greed, competitiveness, viciousness, neglect, hatred, and violence - to name just a few - that some of them have endured or even enacted. And to some degree many of us react by feeling ourselves traumatized from listening to the horrors we are hearing. We may call it countertransference, whether in the classical sense of it being our own neurotic

reactions to the material, or in the more contemporary sense, of it being a feeling residing in the therapist, emerging from the two-person system co-constructed with a patient. While often conveying something about the emotional state of the patient, our feelings may also reflect an analyst's more personal reactions to the material.

However you look at it, it hurts. Some of us suffer in silence, perhaps afraid our traumatic counterreactions betray some inner defects. Others may complain of burnout, feeling we have just had too much of our work and need to pull back and re-charge our internal batteries. Some colleagues even leave the field because of countertrauma.

Yet in our writing, and even in our supervision, we rarely describe our internal experiences with the same vivid, visceral particulars that we ask of our patients. Through detailed inquiry, we ask patients to disclose traumatic material in order to release them from a self-enforced secrecy, help them put into words what has never been linguistically encoded, and assuage the isolation that lonely silence has created. We may not consider that the same is needed by the countertraumatized among us as well. We also need to discover ways to encode our experience linguistically, to talk about it in detail in an environment that does not pathologize our internal reactions, and in so doing help ourselves feel less shamed and professionally isolated.

But instead, we may unconsciously try to prevent countertrauma by avoiding material we find toxic. We may not ask about early sexual history at all, or if we ask we may not inquire about unwanted sexualized experiences in childhood. If a patient volunteers information about sexual trauma, our questions may inadvertently communicate discomfort that silences the revelations. Or, we may fall into the trap of

assuring a patient that what is past is past and it is time to move on. This, of course, is the unhelpful advice often given by family members and loved ones to a trauma victim who has finally disclosed long-ago sexual abuse.

In any case, usually unintentionally and for unconscious reasons, we may allow the analytic discourse to move to less disquieting material. After all, who among us truly wants to hear about a child's torturous, overstimulating, and ruinous experiences?

Indeed, many abuse victims have told me that previous therapists did not ask much about their childhood sexual trauma, even when the patient volunteered information about it. Others have said they thought they dealt with their traumatic experiences in earlier treatments, but as they responded to my detailed inquiry, they went deeper and deeper into their experience and found dimensions of it were still affecting their everyday life in unsettling ways. Some have said that by not questioning much, previous therapists conveyed they did not really want to hear about childhood sexual trauma. This belief, whether accurate or not, often corresponded to the patient's own discomfort in talking about it. Others have said they protected previous therapists, feeling - again whether correctly or not - that the therapists simply could not withstand the impact of what they might reveal.

Some therapists tell me that if a patient brings up sexual abuse without elaborating, they do not question them, feeling that when the patient is ready he will say more. Perhaps these therapists are counterresistent to hearing about early sexual trauma. Perhaps they are clinging to a technique that is inappropriate with trauma victims. Either way, they communicate that they don't want to hear more. From the patient's point of

view the result is the same: holding back or soft-pedaling the traumatic impact of sexual betrayal.

One man had an extended analysis with someone I respect very much. At the end of that treatment, his analyst gave him my name, referring him to my group therapy for sexually abused men. The man carried around my card for 10 years before, with his wife's encouragement and insistence, he gained the courage to call me. As it happened, group was not appropriate for him, but we started another individual treatment. When we began to talk about his paternal sexual abuse starting at age six, he realized that many details available to him never emerged in his previous treatment. For example, I asked him to describe what was going on inside him every night when he lay in bed listening to his father's ablutions in the bathroom, dreading that this would be a night he heard the creak on the hallway floor as his father approached his room, then the half-choking sensation of near suffocation when his father put his hand over his mouth so no one would hear his cries during physical penetration. Astonished at the bodily sensations and horror evoked by these descriptions, he related them to his sleep disturbance as an adult and his difficulty catching his breath when he was anxious.

The effect on therapists of working with traumatized people has interested many in the trauma and psychoanalytic fields. The phenomenon of therapists who work with sexually abused or otherwise traumatized individuals incurring traumatic feelings themselves has been widely documented.

For example, Dori Laub (1992) has written eloquently about the experience of listening to stories of severe trauma, emphasizing that often the traumatic experience has never before been encoded in language and so remains unformulated (see Stern, 1997):

> The listener to the narrative of extreme human pain …comes to look for something that is in fact nonexistent; a record that has yet to be made. Massive trauma precludes its registration; the recording mechanisms of the human mind are temporarily knocked out…[T]he trauma – as a known event and not simply as an overwhelming shock – has not been truly witnessed yet, not been taken cognizance of…. The listener, therefore, is a party to the creation of knowledge *de novo*…[H]e comes to partially experience trauma in himself…[and] comes to feel the bewilderment, injury, confusion, dread and conflicts that the trauma victim feels. (pp. 57-58)

Laub goes on to describe how this affects the inner life of the listener, and the consequent internal struggle to find a position in relation to the victim that takes into account their similarities while keeping track of their distinct differences:

> The listener has to feel the victim's victories, defeats and silences, know them from within…The listener, however, is also a separate human being and will experience hazards and struggles of his own…While overlapping, to a degree, with the experience of the victim, he nonetheless does not become the victim –

> he preserves his own separate place, position, and perspective; a battleground for forces raging within himself, to which he has to pay attention and respect if he is to properly carry out his task. The listener, therefore, has to be at the same time a witness to the trauma witness and a witness to himself. (p. 58)

In the literature, this phenomenon has been addressed by a number of writers and variously called "secondary traumatization" (Bloom, 1997), "contact victimization" (Courtois, 2nd edition 2010), "compassion fatigue" (Figley, 1995), "traumatic countertransference" (Herman, 1992), and, most frequently, "vicarious traumatization" (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). These writers and others (see Perlman, 1999) have tried to convey what goes on inside a therapist who empathically and recurrently listens to deeply traumatic material.

Pearlman and Saakvitne (1995) in their classic text *Trauma and the Therapist*, describe "a process through which the therapist's inner experience is negatively transformed through empathic engagement with clients' trauma material" (p. 279). This delineates the experience well, but notice the academic, Latinate language they use. Descriptors like this separate us from our inner visceral experience. Sandra Bloom (1997) uses more vivid short words to describe how she "did not want to know this…it scared me…it made us sick…at heart, sick in our souls, and sick to our stomachs" (p. 7).

How do we differentiate between vicarious traumatization and countertransference? Pearlman and Saakvitne (1995) note the two can appear simultaneously, sometimes intensifying one another. Unlike vicarious traumatization,

according to these authors, countertransference can be helpful to the therapist, and indeed some countertransference reactions can potentiate the effects of vicarious traumatization. (Perhaps this is the beginning of what I would call a counterresilient reaction.) While this distinction is important, it also forces a false dichotomy, since traumatic reactions in the therapist become melded into countertransference reactions over time.

Interpersonal and relational psychoanalysts who focus on the two-person, co-constructed analytic dyad take note of the full spectrum of contrapuntal internal reactions flowing between patient and analyst. Thus, like Wolstein (1988), for example, we speak of transference and countertransference, anxiety and counteranxiety, resistance and counterresistance, with the terms signifying the reactions of one or the other member of the dyad. In this spirit, I am speaking of trauma and countertrauma, implying a fluid, intersubjective, two-person system, rather than "vicarious traumatization," which seems to imply a one-person model, with trauma residing first in the patient, then transferring to the analyst, both distinct from countertransference.

The writers who address the phenomenon come from both the psychoanalytic and trauma worlds. I have often lived at the intersection of these fields, sometimes being perceived by trauma and cognitive behavioral-oriented therapists as too psychodynamic, and by some psychoanalysts as paying too much attention to reality and not enough to unconscious processes. Hopefully this has diminished over the years.

Countertrauma seems nearly inevitable for a therapist who over time listens empathically to stories of trauma. It happens for those of us who treat both victims and perpetrators of sexual trauma as well as for those who bear witness to histories of

physical abuse, familial suicides or murders, wartime trauma, torture, natural disaster, and genocide, to name only a few.

For many, countertrauma is accompanied by a counterresilience reaction to the resilience exhibited by trauma victims on the face of terrifying, heart-rending experiences. This has been called "vicarious transformation" (Saakvitne & Pearlman, 1996; Pearlman & Caringi, 2009) and "vicarious resilience" (Hernandez, Gangsei, & Engstrom, 2007; Engstrom, Hernandez, & Gangsei, 2008). But, just as the term countertrauma focuses on the dynamic between patient and therapist, I think counterresilience captures the ongoing give and take in the therapeutic dyad that for me is the essence of the healing effects of psychotherapy and psychoanalysis.

Counterresilience results when a therapist is actively involved in the real substance of the trauma suffered by the patient, both the external events and the internal reactions and processing of those events. This robust participation allows the therapist to experience personal growth through the mutuality of the therapeutic dyad. Through personal engagement, the therapist gains insight into the singularity of how the survivor's resilience has allowed him or her to surmount dreadful experiences, even at a terrible psychic cost. (For further discussion of counterresilience, see Chapter 1 in this volume.)

Therapists are not the only professionals to suffer from countertrauma and counterresilience. Peter Nickeas, an overnight crime reporter for the Chicago Tribune, has covered over 400 shooting crime scenes. After the 4th of July weekend of 2015, when there were 82 shootings in Chicago resulting in 16 deaths, he was interviewed by Bob

Garfield for the New York Public Radio (WNYC Radio) series *On the Media* (Nickeas & Garfield, 2015, reproduced with permission of *On the Media*, WNYC Radio.). Garfield asked him: "What kind of effect does it have on you? Tell me about your soul. Do you have any left?" Nickeas responded:

> I have…less faith in people…than I used to. You…see so many bad things [and decide] people…will disappoint given the opportunity. But…I was talking to a woman [who said], "Yeah, my family was the second black family in the block. We were so proud when my parents bought the home…I'm not going to let [them] run me off." That…restores your faith…This job has made me hypersensitive…to…people's emotions. [If] you try to throw up this shield as a defense mechanism, [then] you're not going to be a good reporter. The stories I'm most proud of were showing moms using a dead kid down the street as a lesson to their kids. You see people praying over their dead loved ones…If you say, "No, I'm going to steel myself…, I'm not going to let it affect me," [then] you're not going to get any of that… I'm more able to connect to people than I was…, which is a good thing… I have a hard time sleeping…and then not sleeping aggravates everything else, so I have a shorter fuse… I can keep it in check. I can feel my blood boiling - I don't punch walls, but I can feel myself getting enraged a lot quicker than I used to.

I presented versions of "Trauma and Countertrauma, Resilience and Counterresilience" approximately 15 times over the course of the two years after its first presentation. In several of those readings, I did indeed encounter moments when I had to stop to regain my composure in order to continue, although I never broke down the way I had feared I might. When I finished reading the paper, there was usually a long stunned silence as people took in my intense reactions to working with Duncan.

In the Q&A sessions following my presentations, I often heard from clinicians who were struggling with how to deal with working with traumatized patients. Occasionally someone voiced feelings of being overwhelmed and re-traumatized by what they heard me say. I therefore began to tell audiences that the paper might be difficult to hear and they needed to practice self care and even leave the hall if necessary.

But most members of the audience had more positive reactions to the paper. They were reassured and comforted to hear that an experienced clinician could acknowledge feelings similar to what they experienced but might not be able to voice to supervisors or even to themselves.

Hearing their comments, I decided to make this a larger project, to ask senior colleagues to write about their own internal reactions – both positive and negative -over the years to their work with severely traumatized individuals. This book is the result. My goal is to give other clinicians, whether experienced or new to the field, models for voicing concerns and musings about how they are affected by their work.

I wrote to some of my most respected and senior colleagues from the trauma and psychoanalytic fields, inviting them to contribute to this volume. Nearly all those I

invited were enthusiastic about the project, although not all could accept my invitation. Some elected to exercise self-care by not taking on another project in a professional life that was already too full. A few felt the wounds from certain aspects of their work, particularly with Holocaust victims and HIV-AIDS patients, were still too painful and raw to be revisited through writing about them at this point in their careers.

Yet I am gratified that so many talented and esteemed clinicians agreed to participate. The result has been a group of essays capturing a wide swathe of reactions to listening to and working with traumatized individuals.

The contributions are as varied and distinctive as the writers themselves. Sandra Bloom and Christine Courtois take the opportunity to give us a view from within of their distinguished careers. Philip Kinsler and David Lisak write about how childhood experiences related to the Holocaust set the stage for them to do trauma work. Sandra Bloom, Steven Gold, Elizabeth Howell, and Sheldon Itzkowitz use their essays as a jumping point for advancing theoretical understanding of trauma and its effects. Jill Bellinson, Alison Feit, Jane Gartner, Steven Gold, and Elizabeth Howell (among others) articulate their thoughts about resilience and counterresilience. Most essays describe work with specific patients, but several contributors (Richard Chefetz, Karen Hopenwasser, Ruth Livingston, Mikele Rauch, Kathy Steele, and myself) focus in an experience-near manner on what it is like to sit through the treatment of one or more severely traumatized individuals.

Some contributors write about the effects of dealing with specific populations: Judith Alpert about students' traumatized reactions to learning about trauma; Jill

Bellinson about disaster work; Christine Courtois about betrayal by colleagues; Jane Gartner about teachers whose lives and livelihoods are threatened or destroyed; Karen Saakvitne about supervising and consulting to countertraumatized therapists. Several writers address self-care in very different ways, including Judith Alpert, Jill Bellinson, Christine Courtois, Karen Hopenwasser, Sheldon Itzkowitz, Philip Kinsler, Mikele Rauch, Karen Saakvitne, and myself.

I invite you to consider these changes as described by this extraordinary group of clinicians.