

Vicarious Trauma: What are the protective measures?

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In my 30 years working with sexual offenders as a therapist, clinical supervisor, program director, and now agency director, I have spoken with several colleagues who have decided to leave the field of sexual offender treatment and management because of the impact that working with sexual abuse cases has had on their lives. They reported struggling with intrusive thoughts and images of the offenses they read about or heard from victims and offenders on their caseloads. They felt anxious and depressed from a career of worrying about the risk of their clients in the community. They experienced the relapse of their clients as personal failures. The cumulative impact left many of them feeling emotionally disconnected from their loved ones, less safe, and more fearful for the safety of their children. Many mental health providers and criminal justice professionals working with sexual offenders reported similar symptoms of re-experience, avoidance, and hyper-arousal – the DSM-IV-TR's symptom criteria for trauma. Their symptoms were not caused by directly experiencing the trauma event. Their trauma was caused indirectly, vicariously, and can be as disabling as if it was experienced first hand (Bride, 2007).

Through the past decade, the field has moved towards clinicians, probation/parole, and victim advocates working more closely together to form a treatment and management team. This has not only given us an opportunity to be more effective in reducing recidivism in sexual offenders, it has also created a forum for a cross discipline discussion about the emotional and psychological impact of long term exposure in working with sexual abuse cases. It is only in the past several years, perhaps, in part due to the effect of 9/11 and the global fear of terrorism, that there has been an increased awareness and willingness to discuss the potential psychological harm caused by exposure to the trauma of others. There is growing understanding that the daily tasks of treating and managing sexual offenders and their victims is analogous to being regularly “exposed” to harmful “toxins”. These toxins include viewing images of child sexual abuse and child pornography, hearing and reading victim impact statements, listening to an offender describe his brutal rape or sexual abuse of a child, and hearing about deep neglect and deprivation in the offender's history. This analogy has resonated for many who have endured a career of exposure to the effects of sexual abuse. Research has indicated that continuous exposure to the profound trauma caused by victimization may lead us to manifest the same or similar symptoms as the victims with whom we directly and indirectly interact (Pullen & Pullen, 1996). Developments in neurobiology and the treatment of psychological trauma offer interventions that can help us manage and potentially protect us from the impact that these “toxins” have on our brains, as well as our minds and our lives.

The symptoms of secondary trauma, also known as vicarious trauma, are essentially the same as primary trauma. “Secondary” refers to proximity to the traumatic event, not to the degree of impact. The impact of vicariously or secondarily experiencing a traumatic event can be as powerful as experiencing the event first hand. Our own history of victimization, how we set our personal boundaries,

our psychological defenses, and our capacity for empathy are significant contributing factors to what makes us vulnerable to vicarious trauma (Pullen, 1999).

Trauma is a result of experiencing an emotionally overwhelming event. “Overwhelming” means that an event has created an emotional impact that cannot be integrated into our common understanding of ourselves in the world. The consequence of this is “low mode processing” and emotional dysregulation (Siegel, 2006). The major symptoms indicative of a traumatic experience are described in the DSM-IV-TR as re-experience, avoidance, and hyper-arousal. Trauma can cause a replaying of the traumatic event through intrusive memories. Alternatively, trauma can result in becoming avoidant, disconnected, and dissociated as a way of keeping emotional pain out of conscious awareness. Memories and sensory experiences become triggers which can generalize and cause chronic hyper-arousal and emotional dysregulation.

Understanding the neurological/psychological processes that cause us to feel the impact of a traumatic event vicariously can lead us to protective strategies and remedial interventions. Ironically, empathy, one of a professional caregiver’s most important tools, may put us at greatest risk to be harmed by the work we do. While it is necessary for caregivers to feel concern about the harm caused to and by the people with whom we work, is it necessary to emotionally experience the harm caused to them as well?

Neurobiology’s recent discovery of “mirror neurons” in the human brain shows that we are neurologically engineered to read emotional cues from others, perhaps, as a way of quickly communicating danger as well as determining who we can trust (Siegel, 2006). Mirror neurons help us to understand a number of human features—from imitation to empathy, and language learning. It has also been claimed that damage in these cerebral structures may be responsible for mental deficits such as autism.

We are instinctively drawn to stories of other’s plights. Our culture and the arts exist, in large part, because people can be emotionally moved by symbols, representations, and depictions of others’ personal experiences. We value art that stirs us emotionally. Our ability to have empathy and compassion for our family and friends is what creates the bonds that connect us. Our attunement to our children is what builds their sense of security in attachment to others. When we listen to our clients, victims, or offenders; when we read their stories; and when we view pictures of abuse, we tend to use the same empathy, attunement, compassion, and identification that we use with our family and friends. When our family and friends are in trauma, we feel it acutely and struggle to be supportive and helpful. The closer the trauma is to us, the harder it is to manage.

As professional caregivers we routinely put ourselves in the world of other people's trauma. If we use the same relational abilities that we use for our family and friends, then we will be living in the trauma of others. As a result, we become vulnerable to the same feelings of lack of control, fear, and anger. We can become as emotionally dysregulated as the victim. It is our empathy and attunement (activated through our mirror neurons) that reflexively causes us to bring what we see and hear into our own experience. It is this mind set that creates our vulnerability to vicarious trauma.

The research on trauma from neurologists like Dan Siegel (2006) and Martin Teicher (2002) helps us understand the profound impact that trauma has on our brain. From their research, we have information about disruption in the flow of information from the right to the left hemisphere of the brain in people who have been traumatized. Consequently, the prefrontal cortex cannot create a coherent narrative that the mind can integrate into one's current sense of self. We also have information about the damage caused in the temporal lobe when cortisol is released under extreme stress, which can create hyper-arousal.

The extensive work that has been done in developing Eye Movement Desensitization and Reprocessing therapy (EMDR—Shapiro, 1995), has also had a profound impact on the treatment of trauma. This treatment draws on a similar theory to Siegel's—that emotional regulation can be achieved through techniques that further brain processing and integration. Shapiro found that engagement in eye-movements compared to the eyes-stationary condition resulted in significant reductions on measures of vividness and emotional valence for both positive and negative autobiographical memories. Reductions in electrodermal arousal were only observed when engaging in eye-movements following elicitation of the negative memory. This treatment is believed to help restore emotional regulation by intervening on how emotions and memories are processed by the brain.

A core contributing symptom to emotional dysregulation is the feeling of being alone, emotionally isolated, and disconnected from others. We have decades of information from attachment theorists, object relationists, trauma researchers, infant researchers and, now, neurologists that attachment is primary in human development. The consequence of broken attachments, insecure or inconsistent early attachments, and abusive attachments are proposed in research to be causal for juvenile delinquency, sexual and general violence, and other criminogenic needs. Now, with new research in neurology, we have evidence that our mind may actually be formed in response to the interpersonal connections that develop throughout our lives, for better and for worse.

Siegel's work (2006) suggests that trauma causes profound insecurity and disconnection in our attachments to others, which is partly responsible for the emotional dysregulation we see in trauma

victims. He suggests that it is the process of building back intimate connections to others that is most important for the recovery from trauma. In their research on self-esteem, Spencer, Josephs, and Steele (1993) note that the requirement for enduring self-esteem regulation/stability requires being able to turn to affirming intimate connections to others for a reaffirmation of one's sense of self. When meaningful connections have been broken, self-esteem regulation is often managed with compulsive and impulsive behavior patterns. These patterns become strategies to self-soothe, distract, and avoid the pain and anxiety of a dysregulated sense of self. The symptoms of trauma victims can be understood in this same way. The research on resiliency and protective factors from vicarious trauma all echo the factors that are prescriptive for a healthy life—balance, boundaries, and connections (Saakvitne & Pearlman, 1996). Judith Herman (1992) points out in her work on trauma and recovery that safety, mourning, and reconnection are requirements for trauma recovery. It is clear that trauma protective and recovery strategies all focus on building affirming intimate relationships. This is considered to be intrinsic in developing emotional regulation.

Providers are challenged to bear witness to the impact of trauma without defaulting to the blunt defenses of callousness and indifference. Is there a middle ground of maintaining empathy and attunement without feeling the trauma? If so, how do we achieve it? If we are evaluating and assessing a case by reading material, viewing images, and interviewing a client, we strive to be objective and not let our feelings or underlying emotions influence our judgment. We struggle to find ways to erase the disturbing elements of the case and move on to the next. When we are working with a victim or offender, trying to aid them over time in their process of recovery through supervision and treatment, the added dimension of forming an ongoing professional relationship strains our ability to be just understanding and not also emotionally reactive.

It is possible to maintain an empathic understanding and connection with others about their experience—without becoming emotionally dysregulated. In Siegel's (2007) work on Mindfulness, he discusses emotional regulation. He suggests that “we create nonreactivity by developing the circuits in our brain that enable the lower affect-generating circuits to be regulated by the higher modulating ones.....this is called ‘response flexibility’—the way that we pause before action and consider the various options that are most appropriate before we respond”. Siegel describes how states of “mindfulness” can be achieved when we coordinate our autonomic systems with our intentional systems. For example, breath awareness can create a state of mindfulness that leads to emotional regulation, emotional integration and, ultimately, resiliency. He suggests that while an intimate interconnection to others helps with emotional regulation, an intimate intraconnection between our brains and minds can also directly impact emotional regulation.

While employing techniques that advance mindfulness and meditation may build deep and enduring emotional regulation and resilience, there are also other psychological, neurological, social, and

professional interventions that can be protective. Just as group interventions with offenders have been found to be effective in reducing risk factors like loneliness and emotional disconnection, specially designed consultation and debriefing groups for caregiver professionals can be an effective protective factor. These groups can offer ongoing training about trauma protection, provide support, and help maintain connections to other professional. This kind of intervention can address the core protective factors of “balance, boundaries, and connections”.

The DSM-IV-TR’s definition of trauma describes symptoms of dysregulation that involve memory. New research in related fields may also be helpful as protective measures to vicarious trauma by disrupting memory formation and creating a protective distance from the images and descriptions of trauma.

For viewing images of sexual abuse, research on visual perception suggests that there are some strategies that can interrupt the process of remembering visual experiences. Recent research (University of Oxford, 2009) has shown that for healthy volunteers, playing ‘Tetris’ soon after viewing traumatic material in the laboratory can reduce the number of flashbacks to those scenes in the following week. These researchers believe that the computer game may disrupt the memories of the sights and sounds witnessed at the time, and which are later re-experienced through involuntary and distressing flashbacks of that moment. The Oxford team showed a film to 40 healthy volunteers that included traumatic images of injury from a variety of sources. After waiting for 30 minutes, 20 of the volunteers played ‘Tetris’ for 10 minutes while the other half did nothing. Those who had played the computer game experienced significantly fewer flashbacks to the film over the next week.

While this intervention did not interfere with the responsiveness during the experience it did interrupt the retention of the experience and, perhaps, the binding of emotion to memory. Much like the experience of forgetting where you parked your car when you return from shopping or seeing a movie, intervening experiences that are absorbing can disrupt memory formation and the impact of the preceding experience.

Similarly, it was found that using distracter images that disrupt the viewing sequence of disturbing target images can interfere with memory formation of the target images. Target images should have minimal eye movement and distracter images should have maximum eye movement (Olson, Sledge, Moore, & Drowos, 2008). In another, similar study, it was found that demanding visual search tasks requiring sequential shifts of spatial attention which were interposed during delays of the target image viewing impaired binding memories and features in the target image (Johnson, Hollingworth, & Luck, 2008).

This research on memory formation offers us evidence to suggest new protocols for managing the exposure to potentially traumatizing material. We should routinely be measuring the time of day and amount of time spent being exposed to potentially traumatizing target material. Off-task activities should be planned to distract and disrupt the emotional attention paid to the on-task event. Spending 15 to 30 minutes of time engaged in distracting and memory disrupting activities (like playing “Tetris”) and viewing other distracter images should be considered. Even though this is new research, it offers evidence for a possibly powerful protective intervention.

Other interventions can be developed based on the understanding that our brains connect what we see with what is familiar. We instinctively try to bring what attracts our attention closer so we can better process it emotionally and decide if it’s a threat. Certain interventions can throw our brains off track and trick our minds making it harder for us to bring what we see and hear closer to our experience. Another study from Oxford found that when viewing potentially disturbing images, it may be protective to distort the image. This study found that distorting images of one’s own hand or arm injury by viewing the injury through inverted binoculars with the image appearing very far away reduces reports of pain, as well as swelling and recovery time from pain. Conversely, magnifying the images increases pain, swelling, and recovery time (Moseley et al., 2008). Just as we might be inclined to peek through our fingers when watching a frightening movie, in attempt to make the image smaller or distorted when it is too overwhelming, distancing the images changes proximity; thereby, distorting the perception of these images and consequently making them less threatening. Another study on visual fields found that viewing images only through the right eye (right visual field)—which activates only the left hemisphere (left brain)—will be weaker in storing emotional memories. The right brain, left field of vision, is better for storing emotion/fear based images (Kensinger & Choi, 2009).

The research above suggests that creating the perception of distance between us and the image, or viewing images through our right field of vision, may reduce the tendency to react to what we see with strong protective emotions. We can interfere with our tendency to emotionally identify with others by not only creating the perception of distance, but also by reducing our search for relational cues in scenarios we hear about and view (i.e., not looking at or imagining faces and other body language indicators of fear, pain, and suffering). This would be an attempt to achieve awareness of an event and all its implications without activating in ourselves the same fear, pain, and suffering of the victim.

The power of suggestion is also a significant tool used throughout our culture (cf. advertising). A recent study showed that being instructed to forget an image before viewing the image showed a positive effect in the subjects forgetting images when measured against a control group (Fawcett & Taylor, 2008). Our psychological perspective, as well as our visual perception, influences how we are affected by what we see and hear. Using the power of suggestion and adjusting one’s mind set can be protective

when creating an alternative narrative going into a potentially vicariously traumatic situation. An example of an alternative mind set is:

I am going to look at images or hear about sexual abuse. These are images and stories of people being harmed. While I take in this information, I will be aware that the emotions I find in these scenarios are not mine. If I also find my emotions from my experiences, I will recognize the difference. These events are from the pasts of other people. I do not have control over what happened to these victims. There is violence in the world that I cannot stop. I am working to help stop this from happening again. I do not have control over what happened in these events. I am not going to imagine that this is happening to me, my children, and my loved ones. They are not being harmed. I have empathy and compassion for the pain of others but, today, I am going to just understand and not feel the victim's pain.

It is necessary to develop protective protocols based on the research of the effects of trauma, as well as applications of science from related fields, in order to protect criminal justice and mental health professionals from being harmed by the work they do. There are several kinds of interventions that can have a significant impact on reducing the effects of and the risk for traumatization. Improving emotional regulation following trauma by utilizing EMDR treatment and Mindfulness techniques can improve resiliency and functioning. Group support, training, and debriefing can mitigate the isolation that occurs when professionals struggle with difficult emotions on their own. Developing protocols that utilize techniques that disrupt memory formation like Tetris and using distracter experiences, as well as using techniques that alter perception by distorting distance and changing fields of vision also need to be considered. Readjusting our mindset, by consciously reorienting our cognitive and emotional process through narrative statements, can provide instructions to our minds about how to think and feel about what we see and hear.

In a world that is wrought with terror and trauma, there will always be a need for professionals to attend to the impact of psychological trauma that can resound deep into our social fabric. Protecting our healthcare and criminal justice professionals is a serious public health concern. While there are some who have protective measures built into their minds from stable and secure current and early life experiences, many are not as fortunate. Our field needs to continue to research and develop these and other protective protocols for the health of the professionals doing the work and to maintain effectiveness with our clients.

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