

UNDERSTANDING DANGERS OF EMPATHY By **Babette Rothschild**

Ruth, 42, had recently begun a new job as a social worker, specializing in emergency relief with a family-services agency. An experienced professional, she loved the challenges of this work. She enjoyed helping desperate people, and got a sense of victory from making hard-to-get resources--aid, housing, money--materialize, as if from thin air. But after a few months at the agency, she was dreading her work. Almost as soon as she began her day, she felt exhausted and depressed. She felt so depleted, she was afraid she'd have to quit and go on disability. She despaired at the thought that she might have to give up work that meant so much to her, and she had no idea what to do next. Ruth's agency engaged me as a consultant-supervisor. In a group meeting that I conducted with Ruth and her coworkers, Ruth bravely revealed her predicament. "How long had she been feeling this way?" I wanted to know. To the best of her recollection, she said, it had started in the last few weeks. "Were there any unusually difficult new cases during that time?" "Yes, there were," she said, and proceeded to tell the group about a case she found particularly troubling--a woman who'd fled from her violent and abusive husband to a woman's shelter, which had referred her to Ruth's agency for additional assistance.

As soon as Ruth started speaking, she showed signs of traumatic stress arousal: her skin became pale and clammy; her hands shook. I asked her to pause and focus on her body. Was she aware of any physical sensations at the moment? She said she felt cold, sweaty, and shaky. When I asked what she was feeling, she began to cry. "What's happening to me?" she sobbed. "I used to be able to handle much more than this!" She couldn't stop the flow of emotion. Luckily, it came in a small-group context, among supportive coworkers.

Though Ruth's reaction was intense, it wasn't unusual. Emergency relief or other work with traumatized people is always demanding and wearing: it frequently poses the risk of vicariously traumatizing caretakers, and yet, our field isn't well prepared to help them. As a matter of course, we recommend supervision for therapists and social workers, and we encourage clinicians to discuss difficult cases with colleagues, but we don't always recognize that, for people working with traumatized clients, just talking about it may not be enough.

Trauma--whether the client's original injury or the clinician's vicarious injury--happens as much in the body as in the mind. All of us experience the effects of trauma in the arousal of our autonomic nervous system, the fight-or-flight reaction. Discussion about countertransference or how clinicians' own issues might impede therapy may not get at the somatic effects of vicarious trauma, leaving helpers just as emotionally and physically vulnerable, though perhaps more cognitively aware of what's happening. Preventing and ameliorating vicarious traumatization requires us to pay as much attention to physical sensations as to emotional reactions.

At Risk for Trauma

When I see people suffering from vicarious traumatization, I evaluate how their actions are putting them at risk. Often I find that how they process the information they're getting from clients--how they hear, feel, see, and respond to the trauma their clients are describing--may predispose them to become traumatized themselves. Second, how they interact with clients, physically and verbally, is another potent factor in their vulnerability to secondary traumatization. And third, I look for personal issues in their lives and memories that a traumatized client's history or current situation evokes.

After hearing Ruth's story, I met with her alone for two sessions. In the first, I asked her to tell me more about the case that was causing her such distress. As she described the details of her client's situation, I periodically stopped the narrative to ask what she was feeling, seeing, and hearing in her mind. She answered easily, with rich and evocative language. As a helper, she was long accustomed to picturing her clients' experiences, conjuring up vivid images of their struggles as she listened to them--almost, in effect, recreating their traumas in her mind.

This is a common strategy for many helping professionals. It can be useful for becoming more engaged with clients, but it poses dangers. A misconception held by many helping professionals is that to help their clients, they must feel their clients' pain! In fact, feeling overly intense empathy can undermine the ability to provide an anchor for traumatically overwhelmed clients. It doesn't help such people to see that a therapist is feeling as provoked by trauma as they are.

When Ruth pictured her client's situation, she wasn't being an objective observer seeing the events from the outside. Instead, she was picturing herself in her client's shoes, seeing the situation from her client's perspective. If a client described an automobile accident, Ruth imagined herself in the driver's seat, frantically trying to avoid the crash. If a tornado had destroyed a client's house, Ruth saw her own home lying in ruins. It wasn't surprising that she was vulnerable to feeling bodily stresses and feelings similar to those of her clients. However, in most cases, she could separate clients' emotional experiences from her own. In this case, she couldn't.

After getting a sense of Ruth's processing style, I explored her patterns of interaction. "How do you sit with clients?" I asked. "What's your interaction like when you're in your office together, working with a client?"

Like most helping professionals, Ruth would either go on site or see clients in her office. Often, she placed a client's chair close to hers or at the side of her desk, so they could, almost literally, "put their heads together." She tended to lean toward clients. As a way of communicating empathy, she'd mirror their facial expressions and gestures. When a client conveyed a pained or sad expression, Ruth responded with the same countenance. Part of this behavior was conscious (she wanted to communicate that she understood and was moved), but part had become second nature, as automatic as breathing.

Finally, I asked Ruth to consider if anything in this client's situation reminded her of something from her own past. That question was more difficult for her to address. Despite having an empathetic style of interacting with clients, she prided herself on her ability to maintain a fair degree of objectivity, neither getting sucked into clients' inner worlds, nor allowing her personal life to interfere with her work. The idea that her feelings would intrude on the job embarrassed her. No, she insisted, she'd never experienced anything like her client's situation with a brutal, abusive husband.

Still, I asked again. "Was there nothing at all in your past that might suggest something like what was happening with your client? If it hadn't happened to you, perhaps then to someone close to you?" Slowly, it dawned on her: she remembered an older cousin, her caretaker when she'd been a child of 10. This cousin's husband had repeatedly beaten her when he was drunk. Ruth had often seen her with a black eye or a split lip. Ruth yearned to help, but was too young and powerless to do so. At that time, during the mid-1960s, no women's shelters were available to give refuge to abused wives, law-enforcement agencies didn't show much concern for protecting women from domestic violence, and the public didn't express sympathy for women stuck with brutal men. Abused women were often blamed for "provoking" their husbands. Like many women of her era, Ruth's cousin had stayed with her husband, enduring physical and emotional abuse for years, until his alcoholism killed him. As a child, Ruth had vowed that when she got older, she'd do something to help others in pain and suffering. In fact, Ruth realized, her fervor for her profession had roots in her cousin's misfortunes. At the same time, Ruth didn't fully appreciate how much the emotional impact of her cousin's trauma was haunting her. Seeing the abused client, she'd suddenly, and without knowing what was happening, ceased being a competent, self-contained, helping professional, and had begun reexperiencing herself as a 10-year-old girl, seeing her beloved cousin being tormented and unable to do anything about it.

HOW TO RETOOL

The three keys to Ruth's vicarious trauma and burnout--how she processed client information, how she interacted with clients, and how personal issues affected her work--all emerged quite clearly. (These keys aren't always so apparent, but in therapy at least one of them usually reveals itself.) The question then becomes what to do. Once we've identified the source of vicarious trauma, how can we reverse its effects and help aid workers in the crisis professions and trauma-treating specialists prevent its recurrence?

To lessen the emotional impact of a client's story, I teach helpers to adjust how they process information: I assure them that they can be sympathetic and attentive without injecting themselves into the story. To understand a client's situation, it isn't necessary to picture it. Sometimes, as in Ruth's case, visualizing traumatic pictures can be disturbing enough to throw helpers completely off stride. Ruth needed to learn how to attend only to the words her client was using--just to listen to them, without conjuring up any of the vivid images they suggested. I proposed she try out different ways of relating to her clients: sometimes attending only to words, sometimes relying on her usual mode of creating images. She could also experiment with creating images of what the client was telling her, but from a perspective other than her own, a perspective she could handle better. She could imagine watching her client undergo the event, rather than visualize it happening to herself. She could imagine the traumatic scene unfolding at a great distance, or on a movie screen, or even on a tiny black-and-white television set. Any stratagem that helps distance a traumatic scene will dampen its emotional power. The idea was to give Ruth a greater sense of control over how she received and processed information.

Ruth and I also worked on the specifics of her professional interactions. What she was doing physically to connect with her client exacerbated the emotional arousal, beginning with the visual images of the client's story. Sitting close to her client, mirroring her gestures and facial expressions, Ruth came to feel nearly what the woman was feeling. The difficulty of this was obvious: a desperate helper can't help a desperate client. To be of any help, one person, however sympathetic to the plight of the other, needs to maintain a sense of calm detachment. Since this person isn't the client, it had better be the professional!

Again, experimentation was in order. I encouraged Ruth to maintain awareness of her body sensations and facial expressions. She needed to practice how to communicate concern without feeling the client's every emotion. She came to the conclusion that she should sit farther away. She placed the client's chair on the other side of her desk, not beside it. The desk provided a natural boundary, which protected her from feeling so much of her client's pain.

Ruth also set out to identify when she was mirroring her client's facial expressions. To make herself more aware of her facial expressions and physical state in general, I suggested that every now and then she take a "mini-time-out" from conversation with her client, emotionally and cognitively stepping back to focus on herself and ask, "What am I doing now?" At these moments, she'd consciously do something different--shift her position in the chair, take a breath, move her facial muscles--and watch how the shift altered how she was feeling. She found that deliberately sitting back in her chair and taking a deep breath cut the flow of the client's emotion into her own body. Much to her surprise, these changes didn't diminish her empathy: as she regained a sense of calm control, she discovered she was more helpful to her clients, better able to lower their anxiety and feelings of distress.

Finally, Ruth had to confront, for the first time in her career, the hidden emotional impact of her cousin's abuse, and how, when she'd met a client suffering the same fate, that memory had loomed up, in all its debilitating power. Personal histories have an enormous impact on everyone's choice of career. For helping professionals, this is a huge benefit, as it generates the emotional electricity that makes us care deeply about what we do. But if we don't know ourselves psychologically--if we're unconscious of our motives, except the most consciously altruistic--we're susceptible to reenacting our past with clients, in ways that benefit no one.

On the job, Ruth needed to learn to separate her cousin from her client, to recognize that nothing about her work with her client now had anything to do with her inability to help her cousin then. She found she could consciously turn on the "professional observer" in her brain, reminding herself she wasn't a helpless child, but a competent, helpful adult, and thus maintaining deep sympathy regulated by mature detachment. Having learned to attain a higher degree of consciousness about how her past was impeding her work life, she restructured her approach to her job.

At the same time, on becoming aware of this shadow-presence in her life, Ruth decided to seek out a therapist for further counseling, both to resolve the issue on a deeper level in her personal life and to prevent its possible emergence in her work. Undergoing therapy would seem a natural thing for a helper in Ruth's position to do. The trauma literature for therapists and other professionals recommends seeking out supervision, case consultation, and their colleagues' support, but, for those suffering vicarious traumatization, it rarely suggests therapy. This is an unfortunate omission. Undoubtedly, some professionals affected by vicarious traumatization are struggling with old, traumatic issues that won't resolve themselves through discussions with consultants, supervisors, or colleagues; for them, working with a therapist is advisable.

Ruth was not so different from the rest of us who work with traumatized people. After all, it's our gift for empathy that draws us to our work. And yet, empathy at full throttle--felt and projected 100 percent with our bodies, hearts, and minds--has its risks. Without some sense of separation, our capacity to help clients erodes. Keeping something in reserve doesn't make us heartless or cold. Far from it: the most heartfelt and healing work we do is when we're in complete possession of ourselves, and can bring to our clients a full measure of thoughtful, problem-solving compassion.

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