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When Is Vicarious Trauma a Necessary Therapeutic Tool?

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Trauma is contagious; its powerful affect and frequently unformulated memories can be transmitted—sometimes nonverbally and often mysteriously—within families, across generations, and from patient to clinician; in the latter case it is commonly referred to as vicarious trauma. In emphasizing trauma's contagious quality, the current paper explores the relationship between vicarious trauma and dissociation. The author reviews a number of neuropsychological, cognitive, and psychodynamic explanations for this uncanny clinical phenomenon and its frequently unremarked boundary failures. Despite its disorienting effect on clinicians, it is suggested that in a long-term clinical engagement with a survivor of massive psychic trauma, vicarious trauma can be essential in helping both clinicians and patients process the traumatic material. Contrasting examples illustrate those occasions in which the emotional contagion can be addressed in treatment using containment, validation, and imagination, and other occasions, when there is no therapeutic contract, and other means must be found to formulate the dissociated material.

Keywords: container/contained, emotional contagion, secondary trauma, uncanny, vicarious trauma

Trauma is contagious. Those who have survived extreme traumatization, an individual assault, or mass terror, and have tried to banish it from their minds can infect others with their unspoken horror and unmanageable feelings. History has taught us that the effects of massive psychic trauma can pass from generation to generation as children live out split off aspects of their parents' and grandparents' unspoken, often unthought—that is unformulated—and certainly unwelcome memories. Kogan, (1995, 2002), Davoine and Gaudilliere (2004), and Faimberg (2005), among many others, demonstrate how traces of these unarticulated memories can be found in second, third, and, now, even fourth generations removed from catastrophic loss.

Clinicians too are susceptible to being infected by their patients' traumatic material, whether it is in the form of a narrative or dissociated memories, and they are also vulnerable to catching, or, as McDougall (1978) puts it most aptly, being "impregnated" by the turbulent affect. We call this phenomenon vicarious trauma. If clinicians are not prepared to listen for and to formulate their patients' dissociated or partly remembered experiences, they may, in turn, dissociate the experiences, leaving themselves open to sudden, intrusive, and often inexplicable reactions not only in the treatment setting but also in their everyday lives.

Agosta (2014) makes a distinction between what he calls emotional contagion and empathic understanding: "Empathy requires more than contagion, namely: a communicability of feelings, sensation, or experience that is further processed by understanding, interpretation and language missing from emotional contagion" (p. 81). The contrasting examples below demonstrate the importance both in acknowledging the contagion and transforming it into empathic understanding in treating survivors of massive psychic trauma, and the consequences that can result when there has not been an opportunity to do so.

This first account is the description of an oral history I was invited to record from an expert witness for the defense of a detainee at Guantanamo Bay.[1] I have chosen to describe this interview in detail because, not only does it illustrate the potentially contagious nature of a traumatic memory, but also, in its aftermath, I became vividly and personally aware of the extent to which dissociative phenomena underlie vicarious trauma.

My respondent was a retired high-ranking military officer and a psychiatrist. He spoke in detail about his evaluation of a detainee in whose defense he was participating, saying how struck he had been by the "sweetness" of this prisoner, whom I shall call Samir. At the outset of their meeting in Guantanamo Bay, Samir had asked if the examiner could check a troubling physical symptom. Instinctively, the psychiatrist understood that Samir did not actually have a physical complaint; he wanted to feel another's touch. As they went together to a cell where a medical examination could be performed, Samir froze. Recognizing that he was having a panic attack, the psychiatrist waited with him until he had recovered, and then made sure it was all right if they proceeded. When he was asked what triggered the panic attack—the concern in the psychiatrist's voice was palpable even four years later –Samir, who was just 20 years old at the time and had been detained for over five years, described what he had been subjected to in that room.

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[1] The Department of Oral History at Columbia University has released a Rule of Law Archive where first-person accounts from human rights activists who organized protests against the detentions in Guantanamo Bay, and from several of the detainees' *pro bono* lawyers have been collected. http://library.columbia.edu/locations/ccoh/digital/rule_of_law.html

As I was taking his oral history, the psychiatrist sometimes had struggled to keep his tone even as he talked about Samir, but I noticed that when he recited the list of tortures to which this young man had been subjected, including one particularly sadistic and humiliating act, his voice sounded quite flat and he lost eye contact with me.

I had been reading records on the interrogation of prisoners in Guantanamo Bay for more than seven years at that point and I thought I was familiar with most of the sadistic measures taken, but I was not familiar with this particular technique, I was momentarily shocked and, simultaneously, I was struck by my respondent's flatness. Yet, I did not pause for further reflection; in fact, my mind recoiled in the face of a scene that was proving literally unimaginable.

If this had been a therapy session, maybe I would have been primed to comment on the sudden shift in affect and my own shock, but I was keenly aware of the perspective that informs oral historians' approach to their interviews and how that approach differs from psychodynamic treatment, so I did not inquire into my respondent's feelings at that moment. Oral historians privilege their respondents' narratives, "our goal is a product with serious social implications" (Mary Marshall Clark, 2005, no page), psychoanalysts privilege the process. Our emphasis is on the narrator, whereas the oral historian's is on the narrative. In fact, the psychodynamic clinician's emphasis is on the treatment relationship. It was reflecting on what happened to me as a result of this oral history interview, and in coming to understand the asymmetrical but interactive process that occurs in working with survivors of massive psychic trauma in long-term treatment that led me to suggest that, under certain conditions, working with vicarious trauma is a necessary therapeutic tool.

For some days after taking that oral history, I thought about my respondent's emotional accessibility, but never once did I think about the way in which Samir had been treated with such wanton cruelty, a scene to which I fleetingly reacted with shock. In effect, I had dissociated the episode which my respondent had described so flatly, giving myself no opportunity to wonder retrospectively what lay behind his flatness.

Several weeks after the interview, I was standing at 96th Street and Broadway, waiting for the light to change, when suddenly a vivid memory of Samir's disgraceful treatment overtook me and I was filled with horror and rage as—in my mind's eye—I saw the 16-year-old prisoner in that barren interrogation room stripped of his dignity, left with almost no emotional or material covering, at the mercy of his interrogators. The scene came fully alive in my mind. No longer focusing on the red light, in a trance I stepped straight off the curb coming as close as I have ever come to getting hit by a cab. When I had regained my composure, I set out to investigate how this now vivid but previously dissociated memory and the powerful affect associated with it had been triggered, temporarily disrupting my awareness of my surroundings.

I imagined the storefronts on Broadway between 95th and 96th Streets as I had approached the intersection and I realized that on Broadway and 95th street there is a Halal food cart with the menu written in Arabic script on the side. The sight of that distinctive script and the smell of cumin-scented lamb on the grill could have set off a string of associations to my concerns about the ways in which our society treats all Arabs as if they were terrorists. I was not consciously aware of that thought at the time, it was an unconscious association, but it would not have been an unusual passing thought for me to have. From there, the association to Samir's dehumanizing treatment was almost inevitable. Without the near accident that prompted my investigation and forced me to articulate the experience, the picture of Samir being subjected to this sadism, that I had unwittingly held in my mind without formulating until that moment, would have remained dissociated, ready to trip me up on another occasion or to intrude into a nightmare.

To review what happened here: My oral history respondent had been vicariously traumatized as he heard Samir describe how he had been tortured. In fact he told me later the encounter was "emotionally brutal." In recounting this brutality as I was taking his oral history, he blunted his affect as a way of getting through the telling and of managing his rage. In closely following his narrative, I too was infected as he told me about Samir's torture, but I recoiled and did not register it consciously at the time. In effect, the way in which my respondent's horror at what he had heard but not immediately experienced seamlessly passed into my psyche resembles the intergenerational transmission of trauma; in this case, it could be argued that it was an internarrator transmission. Had I paused in taking the oral history to ask my respondent to share his feelings at that point, to give us an opportunity to reflect together for a moment on what Samir had endured, the scene and attendant affect would most likely have been mentalized rather than dissociated.

In the conclusion to his recent collection (Cave & Sloan, 2014) of oral histories given in the aftermath of crisis, Cave writes: "interviewers bear the difficult aspects of the narrator's experience even long after the (tape)recorder has stopped" (p. 268). The striking essays in this volume demonstrate how, as the stories are told, the historian's focus on the narrator creates an intimacy and intensity akin to a psychoanalytic session but without the two-person focus that affords psychoanalysts today the opportunity to explore the web of thoughts and feelings that arise when such appalling scenes are being described. These are the reflections that allow the therapist and patient to transform vicarious trauma into a dynamic intersubjective process. Later in this paper I describe a case in which I was able to work through a horrifying scene, fragments of which had been haunting me for several weeks, with a man who was in long-term treatment with me. This treatment brought us both relief from his disorienting and previously unarticulated memories.

Vicarious Trauma: History and Literature Review

In what may be the earliest description of vicarious trauma in a clinical situation, Shatan (1973) described "having nightmares, being unable to sleep, unable to talk normally to other people for days or weeks" (p. 651) after treating a number of combat veterans who had recently returned from Vietnam. Clinicians are changed in fundamental ways, he argued, when they are expected to listen to patients who have been exposed to the worst extremes of human experience.

The actual term vicarious trauma was first used in a series of publications beginning in the early 1990s by clinicians working with survivors of childhood sexual abuse (e.g., McCann & Pearlman, 1990; Pearlman & Sakkvitne, 1995). Using language most frequently associated with cognitive–behavioral theory, these au-

thors describe profound alterations in their own schema or beliefs, expectations, and assumptions leading to an enhanced awareness of the fragility of life, and feelings of helplessness resulting from a series of wrenching clinical engagements.

In the years since then, in psychoanalytic literature the term vicarious trauma is frequently conflated with secondary trauma, compassion fatigue, and burnout (see, e.g., Frawley-O'Dea, 2003; Goren, 2005; Kuchuck, 2008; Reubens, 2007). These terms are not interchangeable; the differences should be clearly understood. Symonds (2010) describes the "second injury" that befalls a survivor when others fail to understand or acknowledge a prior trauma, in effect inflicting a second wound. From this perspective, secondary trauma can and frequently does have an iatrogenic cause; for example, when a hospital mishandles a rape investigation or mental health professionals minimize or fail to validate a catastrophic experience. Or again, in dismissing or diminishing a survivor's traumatic memories, family members and the general public can cause secondary trauma.

On the other hand, compassion fatigue and burnout, like vicarious trauma, are products of therapeutic relationships; they are experienced by clinicians, consultants, evaluators and/or first responders.[2] In this paper I argue that when there is an opportunity to engage the patient in long-term dynamic treatment, vicarious trauma becomes an important tool in the treatment itself. On the other hand, compassion fatigue and burnout can result from briefer encounters or treatments in which there is less emphasis on the relationship and less opportunity for the clinician to reflect on her reactions to the traumatic material. In such cases, it is crucial for clinicians to make provisions for self-care, debriefing with colleagues or supervisors, being scrupulous about taking time for themselves, for sleep, and for exercise. Without these precautions, there is a higher likelihood that burnout or compassion fatigue will arise.

Gartner (2014) introduces yet another term, *countertrauma*, arguing that vicarious trauma implies a one person model with trauma residing first in the patient, then transferring to the analyst. To the contrary, I maintain that vicarious trauma is a dynamic intersubjective process where the question of *residence*, I suggest it is *joint residence*, and how that comes about are among the topics addressed below.

The literature review further reveals that the term vicarious trauma can refer to subtly different therapeutic phenomena. Some authors use it to describe a generalized response to a particular class of cases, captured in Shatan's previously cited account of the personal toll he paid for working with a number of Vietnam veterans. Most recently, Gartner (2014) intends this generalized response in listing the legacy of horrifying memories he acquired in the course of treating many men who were abused as boys, memories that intrude, and stories that leave him feeling somber and disturbed. At the same time, Gartner documents individual cases in which, session after session, he suffers "an increasing loss of equilibrium as more details emerged. I was sickened when I returned home after seeing him." Other authors too use the term to refer to the impact of individual treatments with individual survivors (e.g., Bellinson, 2014; Boulanger, 2003, 2007; Frawley-O'Dea, 2003; Howell, 2002; Kafka, 2008).

Waugaman (2009) considers vicarious trauma to be identification; in fact, he calls it an *over*identification between clinician and patient. Gampel (1998) also refers to the analyst's vicarious trauma as overidentification, arguing that this reaction is likely "to close off the patent's freedom through prejudgment" (p. 352). In the course of this paper, it will become clear that in many cases when clinicians work with survivors of massive psychic trauma, the uncanny experience of sharing the patient's dissociated affect or thinking her unformulated thoughts is not a matter of choice, it is inevitable, or, as Agosta argues, unintentional. Contrary to Gampel's concern, I contend that working through the vicarious trauma does not inhibit but rather frees the patient's ability to express herself, and is crucial to the success of the treatment.

The issue of identification or overidentification leads some to ask whether vicarious trauma is a form of countertransference. Pearlman and Saakvite (1995) propose that in treatment the generalized phenomenon of vicarious trauma interacts cyclically with individual countertransferential reactions in any number of complex ways. Gartner (2014) counters that this is a false dichotomy; in many treatments, he argues, vicarious trauma and countertransference become fused, raising the possibility that the countertransferential aspects of vicarious trauma might be more accurately described as concordant identification. This argument has been made by others including Pearlman and Saakvitne (2005) and Shubs (2008). However, in closely following Racker's (1957) definition of concordant identification, a distinction between concordant identification and vicarious trauma emerges. Racker (1957) begins by describing the analyst's concordant identification with the patient as "based on the resonance of the exterior in the interior, on recognition of what belongs to another as one's own" (p. 312). A vicariously traumatized clinician is, indeed, identified with what she is hearing or imagining, and possibly being infected by that terror. However, Racker is referring specifically to the analyst's ability to identify with the patient's relationship to her internal objects. Being vicariously traumatized does not amount to identification with the patient's *relationship to her internal objects*, but rather with the patient's overwhelming affect and confused cognitive state during a particular event.

Does Vicarious Trauma Inhibit or Enhance the Clinician's Ability to Be Present to Her Patient?

With the increasing emphasis on the role of countertransference in treatment outcomes, psychodynamic clinicians have become aware of the importance of taking seriously feelings that parallel or complement their patient's own, and using them to understand and elucidate the patient's experience, sometimes falling into enactments revealing dynamics that had not previously been recognized or fully appreciated (, e.g., Stern, 2003, 2013). However, vicarious trauma is rarely seen as improving clinical outcomes. Saakvitne (2002) speaks for many clinicians in describing the "negative" transformation of inner experience that occurs as a result of engaging with traumatized clients. Vicarious trauma is often believed to inhibit the therapist's ability to be emotionally present or to

[2] G. Brownstone (personal communication, December, 15, 2015) suggests that compassion fatigue and burnout are based on "projective identification, the therapist is reacting to the patients' sense of hopelessness. By contrast, vicarious traumatization results from the therapist's reaction to the trauma itself. The therapist is traumatized by the traumatic event *there and then*. Even though she didn't actually experience the trauma, but only vicariously, her imagination of the event makes it real enough to have this effect."

intervene effectively. In fact, when clinicians working with massively traumatized patients find themselves, I use the passive form here intentionally, profoundly affected by their patient's experience, there is a danger of steering away from such emotionally laden material in any one of a number of ways. This is often not conscious but rather a defense against becoming contaminated by the disturbing affect that can emerge as one listens to, or imagines, or picks up nonverbal cues that patients are not yet able, do not yet dare to find words to express.

Levine (1995) rejects the notion of contagion, arguing that it does not take the clinician's psyche into account. Clearly, some clinicians are more vulnerable than others to being infected by their patients' horror, but terror eventually can overwhelm even the sturdiest clinician. And when it does, some clinicians deflect inquiry that might lead down a disturbing path with advice, comforting words, encouragement, even, on occasion, sharing symptom checklists. Sometimes this is deliberate, part of a (non psychodynamic) posttraumatic treatment plan; sometimes it is less conscious, an avoidance of painful material, and sometimes it is done in the belief that the patient is being spared by not being asked to go into detail about what she has survived. It goes without saying that under these circumstances the clinician is also spared having to listen to the painful details. (Boulanger [2003, 2007] and Fox [2003] summarize several of these avoidant techniques.) Less frequently, clinicians counterphobically probe beyond the patient's current tolerance level.

In his work over the last two decades, Borgogno (see, e.g., Borgogno, 2014) uses the metaphor of contagion; he emphasizes of the necessity of 'falling sick' "with the same illness which is affecting the patient and then 'recovering' in order to re-mobilize the patient's will to return to life" (p. 8). Other authors (Bellinson, 2014; Feldman, 2015; Goren, 2005; Howell, 2002; Kafka, 2008; Kuchuck, 2008; Shubs, 2008) describe cases where their vicarious trauma has led to striking insights and highly effective treatments.

I contend that not only is it highly likely that psychodynamic clinicians working with patients who have been dehumanized will become infected by their patients' affect, in addition this is an indication that the treatment is on track, even if it is an excruciating track for both patient and therapist, as in the case that I discuss next.

David, a Combat Veteran

David was referred to me by his Employee Assistance Program because he was becoming increasingly angry at work with both his bosses and coworkers. When he first consulted me, he was distraught about his ex-wife's refusal to allow him to visit their young daughter; his experiences in Vietnam appeared to be far from his mind, and for several months I was unaware of his veteran status.

When he did start to talk about Vietnam, David commented that half of his personality had gone since he became numb when he was in-country. Now, 15 years later, he went about his civil service job systematically and battled with his ex-wife over the right to visit their daughter. He spoke with feeling about his loneliness and his suspicions about the people he worked with. As he began to describe certain experiences in Vietnam, he was almost giggly. His thinking became disorganized, his language deteriorated into neologisms, and he was patronizing and dismissive toward me. Confused by these sudden shifts in mood, attitude, and cognition, I would try to clarify what had just happened, but I felt quite sluggish, somehow unable to get any traction in the face of his weaving and dodging, and I would start to feel foggy and withdraw. It took many approximate tellings and many occasions when I felt totally out of touch with myself and with David until I began to realize that my sluggishness was a sign that I did not want to understand what I was beginning to suspect. My mind was being invaded by David's unmentalized thoughts, thoughts that could not be thought; thoughts that neither of us dared to formulate. But I knew it was my job to start forming them in my own mind. As Bion (1958) would put it, I had to let them "sojourn in my psyche" (p. 92).

This was a particularly difficult case in which the task of containing and giving shape to my patient's wartime experience, and validating his excitement and his shame over that experience, left me struggling to make sense of what I was hearing in his presence and what I was experiencing when I was alone or with other people. For what seemed like many months, I failed to join David in unscrambling some memories about his time in Vietnam because the memories were proving literally unbearable to both of us. Perhaps a more accurate word than failed is resistant; I was resistant to knowing these awful truths, although I was not conscious of my resistance. I was trying to avoid the emotional and visual projections that David was psychically pressing on me. Yet projective identification was the only means of communication available to us in which to start to address his particular experience. In retrospect I understand that David was attempting to get me to contain and transform something so absolutely unthinkable that it took months to summon the courage to allow these dissociated impressions to take shape in my mind. At first I was not able to hold up my end of the bargain and allow myself to identify with the projected material. The unintentional contagion made conscious identification, that is empathy, impossible. In the next section of this paper, I consider in detail the dynamics that underlie contagion.

When I finally took hold of myself, I was ashamed of how long I had been sitting in a mute trance as, paralyzed by shame and regret, and further shame over his excitement, David attempted to find a way to get me to listen to his muddled confession.

David had been a member of a platoon that had raped, bayoneted, and burned its way through a South Vietnamese hamlet. He expelled the disordered contents of his mind in the hope that I would contain them and render them less paralyzing. My reluctance to have any knowledge of these atrocities, and so be even a passive witness to them, clearly contributed to my difficulty in allowing them to take shape in my mind and thus help David start to metabolize them.

Between sessions I "forgot" about these confusing moments, but I found myself avoiding movies if I knew that they contained violence, and I flew off the handle with little provocation, or felt like doing so. It took considerable reflection to begin to formulate the unformulated material I was experiencing on somatic, affective, and somewhat bleary cognitive levels, and to link this material, together with my horror and my confusion, to my work with David. I will conclude this account of David's treatment after reviewing the ways in which theorists and researchers suggest how we come to *know* another's feelings and *feel* what is in their minds.

Intersubjective Knowing: How the Contagion Is Spread

We are frequently reminded that our Western notions about and comfort with individual boundedness are not universal. Understanding that this phenomenon is not hardwired, that what appears incontrovertible is open to challenge, has encouraged investigators from different disciplines to offer explanations about how thoughts, memories (not only traumatic ones), affects, impressions, and unformulated material are transmitted nonverbally from one person to another. The studies range from neurobiological experiments to cognitive–behavioral explanations to psychoanalytic speculation. In one way or another, the investigators are seeking to understand the uncanny feeling that arises when our traditional understanding of boundedness is thrown into doubt. How do people catch thoughts and feelings from one another, often without words being spoken?

Mayer (1996, 2007) investigated a wide range of experimental evidence for what she called intuitive or anomalous knowing; anomalous because it defies the commonly accepted understanding of individual boundaries. The studies she cites establish the existence of this phenomenon not only between people who are in the same room but also who are separated by great distances. I confine myself here to the process that begins between two people who are closely allied with one another where a radical extension of knowing, a knowing that emerges from beyond intellect, occupies "body and soul, heart as well as mind" (p. 9) becomes apparent. Mayer (2007) describes a series of experiments conducted in 2001 revealing that in deep meditation the posterior superior parietal lobe goes dark, meaning that all the signals that tell us "where to locate the boundaries that separate us from everything that isn't us . . . the neurons responsible for transmitting perpetual awareness of our individual boundedness in space have stopped firing" (p. 65). In this moment, then, the signals that tell us where we end and the other begins are no longer working. Epstein (1995) was among the first psychodynamic psychotherapists to explore the similarities between psychoanalysis and meditation, pointing out that "meditation can affect the key process of remembering, repeating, and working through" (p. 161).

A more recent neurobiological study based on fMRI imaging, also focusing on couples who are familiar with one another, demonstrates that in threatening situations the barriers between self and familiar other break down. Neuropsychologists Beckes, Coan, and Hasselmo (2013) monitored statistical associations between brain activations in regions responsive to threat and pain, comparing self-focused threats to a familiar friend and an unfamiliar stranger. Finding that social bonding increases the levels of overlap between neural representations of self and other, the authors conclude their report, "familiarity involves the inclusion of the other into the self . . . from the perspective of our brain, our friends and loved ones are indeed part of who we are" (p. 676).

Developmental psychology offers further evidence of the permeability of self/other boundaries. For example, Schore (2001) emphasizes the right brain to right brain interaction between clinicians and patients when the clinicians are experienced as "being in vitalizing attunement to the patient . . . Studies of empathic processes between the 'intuitive' attuned mother and her infant demonstrate that this affective synchrony, which occurs during moments of emotional arousal, is entirely nonverbal" (p. 213). Bucci (2001) has calibrated ways of observing and measuring that nonverbal exchange of information. Her body of work, integrating concepts from psychoanalysis, cognitive behaviorism, and the neurosciences, establishes the existence of subsymbolic systems that are dominant in emotional processing and communication. These subsymbolic systems made up of the tactile, motoric, visual, sensory, and affective senses transmit signals from one subject to another. Similarly, the Boston Change Group (Stern et al., 1998) describes *implicit relational knowing*, in which behaviors that have not been symbolically represented, that is not narrativized, permit information about affects and attitudes to be exchanged and responded to out of conscious awareness.

Psychodynamic clinicians know intuitively that boundaries are more permeable than is normally accepted and they also know—without this necessarily being articulated—that the boundaries between self and other are constantly being negotiated. The contemporary literature contains many examples of transference-countertransference entanglements in which clinicians dream their patients' dreams, bear their anxieties, experience their somatic symptoms, or symbolically somatize those symptoms, fall into their depressive states, and think their thoughts without a word being exchanged. Certainly, that was the experience I was having in my work with David as I became increasingly unsettled.

Massicotte (2014) takes Ernest Jones to task for dismissing Freud's interest in telepathy and the occult as "irrational suspicion." She holds that "Freud recognized the possibility of an excess in communication, a surplus of meaning which demanded an exploration beyond the explicit language of the voice and the body's movements" (p. 100). In arguably the first psychoanalytic attempt to find an explanation for the sense of merger that can arise in treatment, in his paper on the uncanny Freud (1919) described the feeling that "one possesses knowledge, feeling, and experience in common with the other, identifies himself with another person, so that his self becomes confounded" (p. 9). Freud eventually traced this experience to "the phantasy of intrauterine existence" (p. 14).

When experiences of merger and boundarylessness arise in treatment today, like Freud contemporary analysts contend that they derive their power from the unity of early life, from the organism's origins in primary life-sustaining attachment. (See, e.g., Bass, 2001). Klein's concept of projective identification, a phantasy in which an internal object or a part of the self is projected into an other, is frequently invoked as an explanation for the experience of being flooded by a patient's unacceptable and hence split off feelings.[3] Expanding on Klein's concept, Bion's theory of the container and contained goes straight to the heart of the question I raise, namely how do psychoanalytic clinicians understand the transmission of thoughts and feelings between their patients and themselves? To briefly summarize, Bion (1962) suggests that babies project into their mothers the emotional experiences that they are not yet capable of processing on their own. If all is well, the mother's reverie (that Bion calls dreaming) about the baby's distress seamlessly transforms the baby's pain into a

[3] Segal (1977) points out that the aims that underlie projective identification can be interpreted in many ways beyond the one I describe above: to expel unwanted part objects; to possess, control, and/or attack part objects; to avoid separation; and to identify with the other's strength.

palatable form that can be reinternalized. This early interaction then becomes the prototype for the clinical situation in which the patient's unbearable sensations, *beta* elements, as Bion calls them, by which he means raw sense impressions that cannot be linked to one another, making them unavailable for reflection, are projected into the therapist. In an ideal situation, using *alpha* function, the analyst reflects on these chaotic impressions, the *beta* elements, transforming them into *alpha* elements that can be linked together and mentalized, allowing them to take on emotional overtones and convey meaning.

As my work with David became more disturbing and chaotic, it was clear that initially I was not up to the task of transforming the *beta* elements. The shards of dissociated memories that had been projected into me were flooding my mind and I could not make sense of them. In a further iteration of Bion's work, Caper (1998) writes that when there has been a violent fusion of fantasies and perceptions *antialpha function* comes into play, meaning that thoughts *cannot* be fruitfully born in mind but invade and deaden the mind instead, making mentalization impossible. My struggle to understand what was happening between David and me is an example of *antialpha* function; I could not make sense of what was happening in the moment. Instead, as Caper (1998) describes, I felt as if I had lost my mind. There was no reflective space. My clinical task was to understand what David was trying not to know and what I had to know, and I had to find words that we could use together. I had to acknowledge the fact that I was infected by his experience, and come to terms with it.

Deconstructing the container contained interaction, Ogden (2004) writes that Bion's model is centrally concerned with processing thoughts derived from *lived emotional experience* (italics mine). It is of note that Bion developed his theory of *alpha* functioning while simultaneously describing, in the first of his autobiographies, his "lived emotional experience" during the Battle of Amiens some 40 years earlier (Boulanger, 2007; Brown, 2012, among others). So many survivors of adult onset trauma feel that their lives and their psyches have been changed irrevocably by their immersion in annihilation horror; it is as if they have died. Like them, Bion wrote, "I died on August 8, 1918" (reported in Brown, 2012). Yet Bion kept these terrifying memories separate from his theoretical work. In the autobiography, Bion (1982), who was decorated as a hero in the First World War (an honor with which he was extremely uncomfortable), describes how narrow and rigid his thinking became as he prepared for battle: "In desperation I stopped thinking about past or future: I began taking compass bearings of every object within my limited view. To my relief my fear began to ebb away. This scene was to be repeated over and over again in this new horrid shape throughout the war until at last it began to lose its horror by force of repetition" (p. 201).

Bion had learned first-hand about the concrete thinking that occurs during trauma. The emotional and sensory impressions that bombarded him as he prepared for battle, and during the battle itself, had to be fended off, they were *beta* elements divorced from one another leaching the potential meaning out of experience.[4] Nonetheless, consistent with his psychoanalytic times and Klein's theory, in his theoretical writing, Bion sought the template for his idea of the container/contained not in his wartime experiences but in the earliest interactions with the mother. Mitchell offers us another way to think about Bion's work in this regard. In his landmark paper, "The Developmental Tilt," Mitchell (1984) takes issue with that traditional psychoanalytic argument; he insists that it is unnecessary to conflate powerful and primitive feelings with infantile states. Earlier is not necessarily more meaningful or more painful, he claims. Whether, like Bion and Klein, one resorts to what Chodorow (1996) has called the "authority of the past," or one agrees with Mitchell that experiences in adulthood can reach previously unexperienced heights of bliss and terror, we have ample clinical, theoretical, and neuropsychological evidence to suggest that traumatic experience challenges our boundaries as we commonly understand them.

I conclude this section by briefly integrating Bion's theory of mental functioning with what has been learned about the neurochemistry of trauma because the consilience across disciplines is instructive and offers further evidence of the difficulties facing clinicians as they seek to introduce meaning into situations that often seems to defy meaning.

As described above, Bion's *beta* elements characterize concrete and unlinked traumatic impressions that cannot be integrated into long-term memory. Similarly, neurochemically, the flood of norepinephrine that is released during moments of sustained terror overwhelms the hippocampus, whose function is to consolidate verbal memory. During moments of terror, emotional memories and sensory impressions are heightened and, with the failure of the consolidating function of the hippocampus, these affects and impressions are repetitively processed by the amygdala, leading to a confusing disconnect between the affective and cognitive spheres.

The intrusive imagery so familiar in posttraumatic states, the emotional memories and somatic, visual, auditory, and affective sensations that persecute survivors, correspond to *beta* elements, raw sense impressions that cannot be linked to one another making them unavailable for reflection, they are unformulated and consequently dissociated. Traumatic memories, while vivid, are also chaotic; the cognitive memories can be sparse but the sensory memories are powerful and intrusive. My unexpected association between the Halal food cart and the torture of a 16-year-old Muslim prisoner is an example of the triggering function of these unintegrated somatic impressions, impressions that had been transmitted to me by a traumatized oral history respondent. I did not consciously make that connection until I was writing this paper; in retrospect I understand that as I walked by the food cart, the sensory experience triggered the emotional connection and I tripped, almost literally, into a shocking dissociated memory.

Case Study Continued

I left David's treatment as I was staring at him in a trance that was turning into mute horror, beginning to realize what he wanted me to know and simultaneously wanted to deny me knowledge of, what I had to contain and to own if this treatment was to move forward. Finally acknowledging the vicarious trauma, the visual and sensory impressions that were forcing themselves into my mind, disturbing my sleep, making me tentative and jumpy in my

[4] Brown (2012) emphasizes Francesa Bion's contention that her husband carried with him the traumatic effects of the war almost "unchewed" and clearly undigested. I would add that Bion tried to make his autobiographical writing the container for the previously uncontained terrors he had experienced.

waking life, reluctantly I began the work of consciously engaging David in an exploration of his missions in Vietnam and how one had gotten out of control.

I regret that I could not have found a way to bear David's unbearable memories, his guilty excitement, and his paralyzing shame earlier. I was horrified by him as he was disgusted and horrified by himself and his own actions, I wanted him to leave, to take his giggles and neologisms and superior attitude and get out of my office. But my gut instinct, fed not so much by his words (because they did not make sense) as by my imagination and, I believe, a forced merger with him told me what he needed to find words to describe. I did not know if I was up to the task of continuing the treatment. Maybe I could find a coward's way out. I scrambled to keep the scene in my mind's eye, to consider the implications of what I was sensing. I could no longer tell myself that I did not know what was going on, I knew only too well. My mind seemed to be stuttering. "How do I ask him about this? Will he be able to hear me? Will he get violent? I think he's talking about killing women and children, and laughing about it, he could kill me too. But it's clear he can't let himself articulate what he has done. Oh God, he just said something and I literally didn't hear it. I can't understand."

"But," I reasoned to myself, as imagination and reflection kicked in, "kids do go on killing sprees in battle, they egg each other on. Could I get so caught up in the mob that I would start seeing other people's fear as incitement to wipe them out? Would I be turned on by that sadistic power? The fact that I can imagine it, I guess that means that I can talk about it." Even before I spoke up, a shift in my body language or my tone of voice, a correction in the subsymbolic text between us, must have indicated a new readiness to listen and to contain. But I had to be explicit after so many failures.

"David, I think you've been telling me about something you guys did in Vietnam but you're afraid that I won't listen to you or I will be so disgusted that I will stop working with you. But I think you're disgusted too, horrified to know that you ended people's lives unnecessarily, I think you are trying to understand what happened. I will try to listen to you and try to help you think about how it happened." Mitrani (2003) describes this kind of containment as "giving a patient a piece of her mind." That is what I had to do, I had to move beyond the contagion and consciously invite David to enter my mind and fill me with his own horror and incredulity so that I could then start to think with him without condemning him.

As I made myself engage the dialectic between numbing and meaning, starting to ask questions that helped us both begin to think, recreate, evaluate, and reevaluate the experience; as I started to reflect and not simply react to what I was hearing, *alpha* function was transforming the shards of *beta* elements into *alpha* elements that we could both think about. In this way, a third vantage point was introduced between us, opening up the intersubjective space. It was no longer me being terrorized by David, or David feeling ashamed at my poorly hidden disgust, no longer doer and done to (Benjamin, 2004), but the two of us thinking and wondering together. This is what had to be done if we were to construct new meaning that went beyond his frozen state and my vicarious trauma.

The change in my attitude made it possible for David to tell his story more coherently. It was a very halting telling, with constant nonverbal checks to determine how judgmental and rejecting I was being, to check how much more he dared to remember. For a long time, he was wracked with shame and the fear that he could lose control again, the fear that he did not deserve to have a daughter of his own when he had watched other people's children being killed, the fear that his coworkers somehow knew what he had done, the fear that his bosses were sadistically pushing him to see how far he would go without breaking. Understandably—and justifiably—perhaps, David never could forgive himself for the atrocities he had committed. He continued to be lonely and isolated, but as he gave voice to his fears, his paranoia grew less, and his behavior at work was less volatile. In time, he was able to confront his ex-wife effectively and argue persuasively for the right to visit his daughter, a right to which he had not truly believed he was entitled until that moment. As the treatment moved ahead, as our work took recognizable shape, I found I was no longer haunted by David's ghosts. But the knowledge of that platoon's rampage in Vietnam does continue to haunt me.

Getting Past the Contagion

In my work with David I became aware that at certain points the boundaries between us had become permeable. I was flooded with his excitement, confusion, and horror, contaminated by his memories without knowing what those memories were. I had become an unwitting container for his disowned sadism. His words, when words could be found, were as disturbing to me as they were to him—temporarily perhaps even more disturbing. Intersubjective space had collapsed and I struggled to reestablish it, to find a place for reflection, for containing and transforming the disorganized and disorganizing *beta* elements.

The therapeutic task was to turn the unintentional merger with David into an intentional joining. To paraphrase Agosta's words quoted earlier, I had to transform emotional contagion into empathy, to find "the understanding, interpretation and language missing from emotional contagion" (2014, p. 81). To achieve this I had to draw on my imagination to make sense of what I feared I already knew.

It takes imagination to enter the survivor's terrifying and terrified state. It takes imagination to address the contagion and to give words to what has been left unformulated. Bromberg (2013) contends that imagination goes hand in hand with intersubjectivity. Under normal circumstances, this is so, but after a massive psychic trauma, as Gerson (2009) puts it, the third is dead. That is to say, intersubjective space is compromised; it has become dead space. Clinicians need both imagination and determination to recreate that space. One crucial aspect of effective psychodynamic treatment with survivors of massive psychic trauma turns on this act of the therapist's imagination, on having the courage to join someone whose self has collapsed in the aftermath of terror. Loewald (2000) cautions that "if we are lacking imagination we will not get into /a patient's/ experience and leave it untouched" (p. 504). Imagination is the best guide, indeed for many it is the only guide, to entering experience that is beyond recognition.

Finding the mental space to keep such horrors in mind comes about through a painfully gradual process, where the analyst's capacity both to experience the feelings and to bear these experiences in mind is encountered time and again by the patient and is eventually introjected. The process is not only painfully slow, but,

as I have argued throughout this paper, it is destabilizing for the clinician to come face to face with a patients' terror, and to bear the responsibility for containing and taming the unmanageable memories and feelings. When clinicians experience themselves as the external container of their patients' dissociated memories and affects, Bick (1968) points out the "the containing object is experienced concretely as a skin" (p. 134) which, when incorporated, give rise to the fantasy of internal and external spaces. Thus, the treatment is beginning to reverse the experience of boundarylessness. The contagion is being contained.

In addition to containing and imagination, validation is the third essential component in treating survivors of massive psychic trauma (see also Levy, 2004). Validation enables survivors to move beyond dissociation and to confront the traumatic past in the presence of a witness. In the attempt to create a "living" third through actively imagining, joining the other's subjectivity, the clinician becomes a witness who can validate.

In psychoanalytic discussions of witnessing, there is a difference of opinion about the clinician's relationship to her patient, about whether this joining is possible or even advisable. Analysts ask whether the clinician is an outside witness validating the patient's experience or whether she should join the survivor in experiencing what happened. Is this joining inevitable? If it occurs, is this merger mutative or does it foreclose the patient's experience, as Gampel (1998) argues in her discussion of the dangers of overidentifying with survivors?

Poland (2000) maintains that effective psychoanalytic witnessing must be predicated on the patient recognizing the clinician's *otherness*. Under certain circumstances he advocates a "silence of engaged nonintrusiveness rather than abstinence" (p. 18), listening but not interpreting. Poland is urging a partial suspension of classical analytic technique. He concludes that this form of analytic witnessing facilitates self other distinction particularly as the treatment is drawing to a close. Taking a relational approach to his patients, Peskin (2012) endorses the opposite view; he argues it is only when the analyst has performed her task as a witness that she can deal with intrapsychic issues. As Peskin puts it, referring to Freud's classic case of hysteria, Dora needed a witnessing analyst before she could use an interpreting one.

The opportunity to use vicarious trauma as a therapeutic tool, however, is based less on timing than on whether the clinician experiences her role as a witness who has a separate center of subjectivity from her patient, who is "other" as Poland puts it, or whether she experiences some form of merger. Ullman (2006) and Gerson (2009) split the difference, arguing that the clinician's "*involved* otherness" is critical to the patient. Oliver (2001), not a psychoanalyst but a social theorist and philosopher, makes a much bolder claim, the witness should not be the "seeing subject" fixing the other with her gaze; rather she argues "subject and object must be reconciled" (p. 9). Similarly, Mayer (2007) cites one of the respondents she credits with extraordinary knowing, "You read the other person accurately because you *are them, you know them from the inside because you stopped being separate*" (italics mine). In this instance, to use Oliver's words, subject and object have been reconciled.

Eshel (2012, 2013) provides many clinical illustrations of this radical view. Her experiences with patients whose early losses and emotional abandonment leave them contending with feelings of deadness and overwhelming despair lead her to describes a process beyond containing in which there is a blurring of boundaries between analyst and patient; it is neither a one-person nor a two-person treatment, but rather an emergent two-in-one entity, she calls it or "withnessing" rather than witnessing, pointing out that the treatment must go beyond separate subjectivities. Her work captures the ineffable, transient quality of "twogetherness" that slowly transforms. She demonstrates the necessity and uncertainty of entering this often terrifying space with the patient, and having to use imagination to do so. It is in the moment of joining these profoundly damaged patients in their hopelessness that finally she is able to reach them.

It is my contention that for clinicians who are working through the disorienting experience of vicarious trauma, there is both a profound need to stretch the imagination to encompass the other's subjectivity, this time intentionally (and the willingness to take this leap), and at points it is necessary to validate from the position of a concerned other. Joining with and remaining separate are essential at different times. Those who work with massively traumatized patients can point to moments of joining, of putting aside the last shred of dissociation, the last defense against disgust, horror, and overwhelming sadness and consciously coming to know the other from the inside.

Conclusion

To summarize, like all forms of countertransference, of which it is one example, vicarious trauma must become a dynamic intersubjective process. Sometimes vicarious trauma is experienced as a form of psychic contagion, unwelcome and unintentional. Only in acknowledging the contagion can clinicians begin to work through their patients' traumatic experiences. In helping patients metabolize what had initially proved psychically indigestible, clinicians also have to work through their own experience of the patient's experience. Initially, this process unfolds in sessions, but inevitably some of the dissociated affect and unformulated impressions are carried from those sessions into the clinicians' daily lives where the patients' disavowed material can be worked on in sleep states and in waking states and used to propel the treatment forward in following sessions. In working with David, I was finally able to turn my vicarious experience of his dissociated experience into a painful but necessary exploration of a particular incident in Vietnam.

Gandhi is reported to have said, "I will not let anyone walk through my mind with their dirty feet." Psychodynamic clinicians cannot say the same: we must open ourselves to the possibility that our patients will walk through our minds with their dirty feet, and it is inevitable that some previously unexamined and unimagined footprints will trip us up as we go about our daily lives. They are a sign to us that we are engaged in a process, a struggle with ourselves to help a survivor of massive psychic trauma find meaning in the experience, however painful that meaning may be.

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