A set of personal challenges and transformations needed to effectively work with trauma

Ten Life Lessons in Becoming an Effective Trauma Therapist

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I hear over and over again how pervasive trauma is and how we're neglecting trauma and need to be more trauma sensitive and trauma informed to really help people. This seems to be true everywhere I look – homeless people, drug addicts, hyperactive and problematic children, foster kids, transitional aged youth, jail and prison inmates, probation clients, psychiatrically hospitalized patients, returning veterans, battered women, unhealthy people dying early deaths – everywhere that is except DSM which unfortunately is the foundation of our mental health funding and structure. I think that the main reason why trauma keeps re-emerging over and over again only to re-submerge again is that it is impressively emotionally demanding to be a good trauma therapist on a prolonged basis. This paper is an overview of ten lessons I've had to learn over the course of my career to persist as an effective "open minded and open hearted" trauma sensitive psychiatrist over the years. Although many of these lessons have taken me quite a long time to learn, and many will always be ongoing works in progress, I think we should be introducing them early on in the training and development as trauma therapists of all professions.

1) We need to respond to our client's trauma stories emotionally as a fellow human being – with sympathy, compassion, desiring to help, comforting, protective, diminishing their personal responsibility, reassuring, with empathy, connectedness, sharing experiences, desiring to heal, angrily, with resentments, wanting to bring perpetrators to justice, advocating for change, making sure it doesn't happen again, protecting others, sharing blame, building social responsibility, feeling hurt ourselves, overwhelmed, damaged, self-protective, becoming part of their cycle of pain, frustrated, stuck in repetition, manipulated, retraumatizing them, feeling guilt, avoidance, and blaming - rather than by creating some other artificial roles and relationships for ourselves in order to be effective (even if those roles advertise success while allowing us to remain detached – as medical model interventions, many EBPs, cognitive approaches often do). If we don't do this, we have a huge risk of never engaging our clients, being seen as uncaring, only concerned with paperwork and billing, managing an assembly line of cases, and they'll rapidly drop out. Increasing efficiency and effectiveness will not help this, only

increasing emotional connectedness will. They're not dropping out after one session because they're convinced our approaches don't work. They're dropping out because they don't feel cared about and understood.

2) To protect ourselves from emotional burnout we need to replace compassion with empathy. Compassion is feeling our feelings in response to their story. It feeds our own suffering and our burden to help – both useful but draining. Empathy is a vicarious experience of their feelings, sharing their suffering, and leads to feeling quiet, connected, and stronger. Compassion burnout is common. I doubt empathy burnout exists. The vast majority of our likely helpful impact is from Carl Roger's triad –empathy, authenticity, and genuine affection - that nurtures their positive life force, not from any intervention done to them. We should begin with these approaches, not resort to them only after other, less personally demanding approaches fail.

3) Suffering itself is not a sufficient motivator for change – that's why bottoming out, confrontation, weighing positives and negatives, withholding relief / meds don't really work. Having their suffering shared, understood, empathized with, and sat quietly with is a stronger motivator for change. Having someone take away your pain, fix your problem, medicate it, isn't generally effective without sharing the suffering that accompanies the experience of the pain first and ongoing. Otherwise they feel objectified, misunderstood, minimized, and ultimately somewhat cheated by us. People dealing with trauma primarily with DSM diagnoses and medications are likely to feel "pain pills", "antianxiety pills", and "antidepressants", the three largest selling categories of pills, fail to work as as "anti-suffering pills" so they may increase the dosages, becoming dependent or overdosing, or lose themselves in a deadened state. The more we act like we're pills, scientifically effectively acting on them in if they ingest us regularly, the more they will react to us in these same ways – disappointment, becoming dependent, overdosing, losing themselves in an alternate mental health treatment world. Even if we believe that the massive increase in diagnoses and medication of mental illnesses is justifiable – a questionable belief in my view – we still must face the important role of trauma in the vulnerability to, etiology of, progression of, and response to these illnesses. We need to heal suffering, not just reduce pain and other "symptoms".

4) We may feel suffering ourselves from sharing our clients' stories. They may trigger our own underlying traumas. Hiding our own suffering and trying not to feel deadens us and destroys the source of our own compassion and energy for our work. We need to value our own suffering, accepting and valuing ourselves as "wounded healers", understand and use gifts from our suffering, and accept and care for our vulnerabilities.

5) We can intentionally focus on creating a healing relationship between staff and client to help heal their wounds, a "corrective emotional experience". This relationship has to be emotionally sustainable for us and impermanent – so they don't need to rely on us forever. It needs to be a partnership, not a battle. When staff are at risk of being overwhelmed we can strengthen our healing abilities and our protection against vicarious traumatization by joining with co-workers and recovering clients building a program culture and vision of healing that is a specific intentional response to the shared suffering our particular clients bring us. It also has to be sustaining and impermanent.

6) We need to accept that there isn't a way to separate victim and perpetrator, good guys and bad guys. Virtually everyone is both. We need to replace pursuing vengeance and justice for perpetrators – driven by our own anger and resentment - with pursuing acceptance and forgiveness - driven by love for our world of mixed good and bad. Intolerance is the root of all evil – people and actions we cannot tolerate, let alone love, we ascribe to evil, or a secular equivalent like sociopathy. We need to create a very broad "counterculture of acceptance" to connect to "victims", "perpetrators", real people who are usually some of both, and the common multigenerational patterns of abuse and traumatization. Forgiveness doesn't mean it was alright, we only forgive things that are wrong. Forgiveness is not for the perpetrator, they've likely already moved on, it's for the victim. The weak don't forgive, only the strong forgive and it makes them stronger. Sometimes we need to accept and forgive the "perpetrator" in ourselves before we can accept and forgive others.

7) We need to be able to see, appreciate, understand, and accept the traumatizing impact of our services and relationships. There's no such thing as do "do no harm". We harm those most we are in closest relationships with. We need to cultivate an awareness of how we look to our clients, even if it's not how we perceive ourselves. We need to

accept and take responsibility for our roles in inflicting more suffering on our clients while working to minimizing retraumatization, power struggles, and the use of seclusion and restraints. Rationalizing that we're acting in good faith, that we're good people, and that we're doing it for their own good is not helpful for them, or for us. It's holding us to impossible standards, denying the mixed good and bad in everything and everyone, and feeding a blaming, power struggle between us and them that destroys trust between us and builds defensiveness and distance. Also, we need to remember that power is corrupting – for us. When we feel helpless and frustrated or frightened, we're likely to seek out more power without considering the corrosive effects that power will have on us. The more we collect and rely on power to help people, the further from true healing we move.

8) Promoting more social responsibility doesn't have to diminish our client's self-responsibility – it can be social responsibility "and" self-responsibility, not "or". We do want to work together to improve our world, but waiting for others to advocate for clients, to change the oppressive social or personal circumstances – whether it's diminishing poverty, or exposure to community violence, or racisms on the one hand, or wanting their parents or spouse or employer to change because they're harming the client on the other hand – is disempowering and reinforcing of victimhood. Diminishing self-responsibility is crippling no matter how well intended it may be. People need to move from victim to survivor to recover. Taking responsibility for our clients' lives burdens staff and feeds both our and their resentments. It's also ultimately futile.

9) Excusing people from the burdens and expectations of self-responsibility is a very appealing and common way of coping and maintaining difficult relationships - it wasn't their fault because they're "sick". This dynamic may be helping to fuel an explosion of diagnosing people. We seem to have reached the tipping point where the shame of having a mental illness is less than the shame of accepting self-responsibility for our actions. It may seem easier for me as a staff to keep working compassionately with someone who is acting badly towards me, especially dangerously so, if I decide that they're acting that way because they're ill, rather than out of choice. If I proceed even further to decide that they aren't responsible for understanding their illness and taking care of themselves and, therefore, I need to take care of their life and their treatment, I will have bound them to my care forever. We should desperately search for alternatives to this seductive path, highly individualized alternatives that build upon and support whatever - even limited - free will and self-responsibility they have, because without free will and self-responsibility there is no recovery, only custodial care. One of the

significant advantages of trauma models over medical models is that they tend to reframe pathological symptoms and behaviors someone is inflicted with as understandable, but problematic coping skills that they have developed over the years and that they can continue to develop. Nonetheless, both models frequently resort to excusing self-responsibility to gain emotional relief for both clients and staff (and families and communities) emphasizing victimization and unfortunately diverting attention from difficult reparation work.

10) We cannot rid the world of damaging forces, no matter how much we might want to. We cannot insure "this will never happen again". We cannot truly be safe. But that unfortunate reality shouldn't lead us to withdrawal, isolation, depression, deadening of feelings or we've given up on all of life. We can't block out or avoid just bad feelings and relationships – they all come together. Having fun together and enjoying life together can be a powerful motivator to keep clients and staff involved with life despite the inevitable suffering and brings us together. We can also create "protective factors" – a secure foundation from which to take risks, a self identity, relationships and connectedness, spirituality – to build resilience so we can make it through the inevitable next trauma together. Trust is the building material of protective factors – trust in ourselves including our flaws and wounds, trust in our relationships even though we will hurt each other, trust / faith in the world/ God even though trauma and suffering exists.

Taken together these ten lessons have given me an "emotional tool box" to persist as a trauma therapist including: seeking emotional involvement, emphasizing empathy over compassion, sharing and healing suffering, creating corrective emotional experiences and healing program cultures, valuing my own emotional wounds and gifts, promoting a counterculture of acceptance tolerating the mixed perpetrator and victim roles in all of us, replacing vengeance and justice with acceptance and forgiveness including self acceptance and forgiveness, promoting social responsibility and client self-responsibility, facilitating emotional reparation, having fun and enjoying life together, and attaining resilience from protective factors. If I can build a foundation for a "trusting relationship" with myself, my clients, and my world I'm more likely to use my professional skills therapeutically instead of defensively and self protectively.