Victims of Sexual, Physical, and Emotional Abuse


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Countertransference in the Treatment of Acutely Traumatized Children

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The Prevention Intervention Program in Trauma, Violence, and Sudden Bereavement at the University of California, Los Angeles (UCLA) has provided treatment and consultation nationally and internationally for child victims and their families exposed to natural disasters (e.g., earthquakes, tornadoes), violence (e.g., school and restaurant shootings, robberies), accidents (e.g., vehicle, shooting), and war (e.g., Kuwait, Croatia, and Central America). In addition to child victims, interventions have been provided for child witnesses of, for example, rape, suicide, and other injury or death (accidental, deliberate, disaster related). Children from a wide variety of backgrounds have been interviewed and treated; no socioeconomic level is immune to traumatic experience.

Individual children and families in the Los Angeles area are seen in the UCLA Neuropsychiatric Institute (NPI) and Hospital and the NPI child outpatient clinic. Consultations are provided to groups such as schools, churches, and restaurants across the United States and, post-war or post-disaster, to other nations. Consultations include planning, triage, and the training of mental health and on-site personnel in methods of intervention for children exposed to traumatic events.

There has been considerable advancement in the understanding of post-traumatic stress and related symptoms in traumatized children as well as greater appreciation of the complexity of children's subjective reactions (Pynoos, Frederick, Nader, et al., 1987; Yule & Williams, 1990). There have now been several reports of different proposed methods of assessment and treatment (McNally, 1991; Nader & Pynoos,
1991; Pynoos & Nader, 1993). However, there has been corresponding attention paid to neither the difficulties encountered by the clinician engaged in this work nor the specific conceptualization of the countertransference issues. We have supervised and trained child psychiatry fellows, clinical social workers, psychiatric residents, and psychologists in the screening and treatment of traumatized children. Training has been provided at UCLA through class lectures, ongoing supervision, and case conferences, and at other locations in the form of brief didactic (usually 1–2 days) or periodic on-site training sessions. The latter usually entails 1 week every 2–3 months for up to 2 years and has consisted of didactic sessions, observation of the trainer conducting treatment sessions, continued work with traumatized and grieving children, trainer’s observation of trainees, and case presentations. This on-site training is supplemented by continued practice, local on-site supervision, and regular case presentations within the treatment group; the trainer remains available for phone consultations. This chapter discusses some of the countertransference difficulties encountered by trainees, primarily in mastering an active empathic inquiry during the acute phase of trauma treatment of children’s post-traumatic stress disorder (PTSD).

**SPECIALIZED CHILD TRAUMA INTERVENTION**

The UCLA Trauma Program’s assessment procedures for post-traumatic reactions involve two components: (1) the reliable measurement of children’s distress and symptomatic responses (Pynoos et al., 1987; Nader, Pynoos, Fairbanks, & Frederick, 1990; Yule & Williams, 1990), and (2) the use of special interview techniques to explore children’s subjective experiences (Pynoos & Eth, 1986; Nader & Pynoos, 1991; Pynoos & Nader, 1993). One of the first products of our program was an interview protocol that permits a thorough “debriefing” of the child.

The child interview is designed to elicit a thorough account from the child of her or his experience including affective, sensory, and physiological experiences; identifiable sources of traumatic anxiety; traumatic reminders; early coping processes; and trauma-related life stresses. In remembering life-threatening events, children’s recall is not organized as a single episode, rather as multiple traumatic episodes within a single event. Spatial and temporal registration, affective and cognitive responses, sets of perceptions, intervention fantasies, and psychodynamic attributions differ for each moment and memory anchor point (Pynoos & Nader, 1989).

Imagined actions are incorporated into children’s traumatic memory representations. Ongoing intervention fantasies are integral to children’s reprocessing of traumatic events. They include the child’s fantasies during and after the event of preventing or stopping harm, of challenging the assailant, or of repairing damage. Revenge fantasies, for example, rid the child of the external threat while answering the internal threat. When children’s desires to act during an event go unresolved, the result can be a major change in behavior and personality. Lack of resolution of, for example, a revenge fantasy may result in increased aggression or inhibition (Nader & Pynoos, 1991).

Even one interview using specialized techniques to inquire about the subjective experiences of the trauma is helpful to children. The original model of traumatic neuroses as proposed by Kardiner (1941) described a constriction of both cognitive and emotional ego functioning. The goal of the initial interview is to begin ego restoration, which is demonstrated, for example, in the following ways:

1. Children become much less frightened of being overwhelmed by recalling their experiences and by identifying difficult moments;
2. They gain confidence in their ability to anticipate and manage traumatic reminders;
3. Their emotional range increases; and
4. They feel more competent in addressing some of the secondary changes that have resulted.

Moreover, the initial interview begins a process by which the child can engage in constructive intervention fantasies. It also identifies troubling moments that require more time to assimilate and assists children with their expectations about recovery. The clinician acts as advocate and involves others as advocate for the child in order to minimize secondary adversities. Attention is given to achieving the proper closure at the end of the interview to prevent leaving the child with renewed anxiety and an unnecessary avoidance of the therapeutic situation itself.

Children’s memories are context specific. When children have initial difficulty in recall, rather than memory impairment, it is often because they lack an adequate retrieval strategy (Johnson & Foley, 1984; Pynoos & Nader, 1989). In this initial interview, the clinician is providing children with a strategy of recall. The result is an enhanced scaffolding for the children’s descriptions of their subjective experiences.

The strategy of recall becomes a part of children’s memory of the event. Giving children prohibiting or misleading recall instructions may limit memory and thereby introduce distortions. When a child either is told just to forget what happened or is taken only to a certain point in recalling the incident, future memories may be restricted (Pynoos & Nader, 1989). When this has occurred and we see a child years later, the child discusses only the limited portion of her or his experience. There-
fore, the initial interview and the clinician’s ability to explore the traumatic experience thoroughly may be key to the overall intervention with a traumatized child.

One key to intervention is ongoing attention to the reprocessing of both external and internal dangers (Freud, 1926). In addition to the external threat, children contend with a variety of threats from, for example, their physical and affective responses; a sense of helplessness and ineffectualness; disturbances to the emerging self-concept; intrapsychic dangers of abandonment, loss of love, anxiety about physical integrity, and superego condemnation; and disturbances in impulse control and processes of identification (Pynoos & Nader, 1993).

Treatment of PTSD in children can be both rewarding and trying for the clinician. Initially, the therapist takes an active role in addressing the impact of the traumatic experience. Although children may need assistance in understanding the influence of prior life experiences on current traumatic response, it is essential to maintain a primary focus on the child’s full subjective experience and its impact. For example, a 12-year-old girl was taken hostage with a group of her peers, then witnessed the suicide of the assailant. She had previous ongoing issues related to early abandonment by her father. The primary focus of treatment remained upon traumatic issues including fears of being shot or having a friend shot while a hostage, seeing friends crying with fright, hearing an adult try to talk the assailant out of shooting or suicide, listening to the woman dictate her suicide note, seeing the assailant with blood spurting out of her head and mouth, other episodes of her experience and its aftermath, and primary and secondary symptoms. Specific moments of the event may bring up different issues in varying ways. For the 12-year-old girl, in trying to secure a greater sense of safety in examining particular traumatic moments, abandonment themes became a part of her processing and response.

On the other hand, during the course of long-term trauma work, earlier concerns may be addressed as they become enmeshed with trauma issues or become a necessary prelude to some aspect of trauma resolution. Approximately 1 year after treatment began, abandonment became a more central focus of attention for the 12-year-old girl. She was unable to focus on her traumatic rage until these abandonment issues had been addressed.

Expectations about recovery influence children’s levels of ongoing distress. Because children may react adversely to the presence of symptoms, a major goal is to help them to understand that their reactions are expectable and normal. For example, adolescents may look on their post-traumatic stress reactions (e.g., the need for assistance or the need to be closer to parents) as childish. School-age children may feel they should be symptom free after a few months and may therefore attempt to hide or disavow their symptoms. For example, a 3rd-grade boy appeared to become more clumsy after the death of a classmate in a plane crash. He later admitted to the school nurse that he would hurt himself more frequently so that he would have a reason to cry. He felt that the other children were no longer sad and upset about their classmate’s death and would think he was silly for continuing to cry.

COUNTERTRANSFERENCE AND EMPATHIC DISTRESS

The clinician’s role often begins with the phone when parents, school personnel, or other individuals ask for advice. The trauma therapist may be asked, for example, what to tell children about a deceased individual or about the manner of death (e.g., “What should I tell Mary about her father’s murder?”), what to do about relocation (e.g., “Should we move to a new apartment instead of staying here where my husband stabbed us?”; “Shouldn’t they tear down the restaurant where the shootings happened? Every time we go near there, Randy gets upset.”), or what changes to expect in the child (e.g., “How will I know if this has affected John?”). The clinician may respond to the demand (or perceived demand) to solve the impact of the trauma in all of its dimensions through quick decisions about specific family matters. The result may be the clinician’s sense of being overwhelmed or ineffectual. Regaining an empathic, information-gathering stance about the children and the post-traumatic situation may enable clinicians to adequately apply their working knowledge of human and traumatic response to the current circumstances. For example, a guardian may not know that removing the traumatic reminder does not remove the traumatic response (e.g., moving away from home after her father was killed by a robber did not eliminate Laticia’s bad dreams, intrusive thoughts, sense of estrangement, regressive behaviors, irritability, increased somatic complaints, rage, or new defiant behaviors). This principle may be relevant on the community level (e.g., tearing down the fast-food restaurant where the massacre occurred, in response to community outrage, did not reduce traumatic reactions and in fact was problematic when Randy was ready to return to the scene and walk through it as a part of his treatment). There may be social or political pressure to take some definitive action such as tearing down a building (e.g., after a sniper shot children from a second-story window, neighbors wanted to burn or tear the house down; painting the home a different color diminished their outcry). On the other hand, caretakers need to know that
Vicarious Immersion in Trauma: Testing the Limits of Empathy

The anxiety is palpable in the treatment room with victims of trauma (e.g., the severely traumatized child may bring intense traumatic anxiety to the session; intense anxiety may be renewed as the child reenacts or reassembles the scene of the trauma). There are multiple components to the child’s experience and response, and his or her sense of urgency and need for relief may be prominent. The clinician herself or himself may on multiple occasions experience the emotions common to trauma (e.g., helplessness, rage, confusion, desires to repair or retaliate) as well as personal emotional responses and anxieties surrounding what a “good clinician” should do. The clinician is confronted, on more than one occasion during the course of treatment, with the contagion of helplessness and the sense of being overwhelmed. She or he may feel that what happened to the child will always be too much to handle. It is essential to recognize helplessness as part of the traumatic response and as nonbinding on the clinician. As noted in Chapter 2 of this volume, all of these affective reactions are Type I and Type II countertransference reactions.

There are two immediate sources of empathic strain for the clinician: (1) listening to the threat to the child, and (2) listening to the child’s distress at witnessing threat or injury to another, especially to a family member or friend. Interventions with traumatized children include their relating in depth, for example, (1) horrifying images, such as the sight of the man stabbing his victim, the assailant gouging out the eyes of the child’s father, or blood streaming from all of the facial openings of the suicide victim; (2) extremely frightening moments, such as seeing the strange look on father’s face before he lifts the knife to stab his child, looking into the barrel of the gun, seeing the man with the gun get angry, or bullets hitting the pavement to the right and left of the child; (3) extreme sensory moments, such as the knife pounding into the back of the child’s head, or the smell and feel of the cigarette burning the child’s skin; and (4) moments of intense helplessness, such as moments in which intervention is not available or is impossible (e.g., watching a mother die, seeing a father tortured, hearing a wounded child’s cries for help when any attempt to assist would result in death or injury), moments of ineffectualness (e.g., attempting resuscitation of a schoolmate or parent, being unable to pull the assailant off of someone, being unable to pull the knife out of the father’s hands), or the inability to tolerate the internal threat (e.g., not knowing when the gun will go off causing death or injury, murderous impulses toward the assailant or toward a sibling, feeling the heart will explode from pounding so hard and fast). Like others, the clinician may not want to believe that anyone would subject a child to such experiences.

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The desire on the part of mental health professionals and others to protect adult and child victims from further harm can be positive. Protectiveness may result in, for example, appropriate pacing, a sensitivity to the capacity to face specific trauma-related issues, and the imparting of protective information. The clinician’s protectiveness is positive when the clinician acts as advocate for the child, when the protectiveness facilitates the development of a safe environment in which the patient can regress, express fantasies of intervention, and face the overwhelming moments of the experience. There are several common ways, however, in which individuals attempt to provide protection that are contraindicated, as they may interfere with the process of recovery. These countertransference tendencies of overprotection may result, for example, in delaying treatment, in participating in a conspiracy of silence, in avoiding upsetting issues or intense emotions, or in hesitating to push forward or review when looking for missing emotion-laden moments. Lack of protection may occur if, on the other hand, the clinician feels that she or he must remain neutral to the situation when, in fact, action is needed on behalf of the child.

Knowing When to Intervene: Traps and Pitfalls in Countertransference

Deciding when to intervene may elicit countertransference issues surrounding the clinician’s need to rescue or protect, or it may elicit fears regarding doing harm to a child in fragile condition. Errors may occur in an attempt to protect the child from premature treatment. Especially with injured children, the inclination may be to delay treatment until the child has had some time to recover. Sometimes, the overzealous clinician may overprescribe treatment, feeling that every child must be treated rather than assessing the child’s ability to recover within the family context. On the other hand, the clinician may minimize the effects of the experience and may underprescribe treatment. For years people argued that children were not affected by their traumatic experiences (“If you just leave them
alone, they will be fine.”). Even if ongoing treatment is not required following a traumatic event, it is helpful to see children to assist them to understand the event in the context of their lives. One interview can provide the child with a strategy of recall and thus be of assistance later. This is especially true if the child later seeks intervention after ongoing development or life experiences result in reassessment or renewed reaction to the traumatic experience.

Treatment can begin in the hospital. Identifying traumatic reminders in the hospital setting may reduce the child’s distress and may reduce interferences to healing. For example, balloons were sent to cheer up a child who had been injured in a shooting. When one of them popped, the child’s severe startle reaction disrupted intubation, which resulted in increased pain and bleeding in the wound. In the initial phases of recovery when injured children need to focus most of their energy on physical recuperation, they still need an opportunity to retell their experiences and may spontaneously do so. When this happens, a particular bond is formed with the listener. Making contact during the hospitalization is an opportunity to establish an initial rapport with the child, as well as to accommodate the child’s need for recounting what happened and to ensure adequate recall.

Psychiatric interventions, especially with children, traditionally occur after the onset of significant emotional disturbance. It is both easier and less costly to intervene before disorders become fixed and severe. As is true for adult traumatic reactions (Kaltreider, Wallace, & Horowitz, 1979), treatment of traumatized children is most effective in the acute phase of response, when the intrusive phenomena are most apparent and the associated affect most available. There may in fact be a critical period in which to work with traumatized children (Nader & Pynoos, 1988). Traumatic material appeared to be less easily accessible after the first 3–6 months in working with groups of children after their exposure to a sniper attack, a tornado, and a murder.

The Willingness to Hear and the Need for Awareness of Countertransference

The goal of effective intervention is to hear everything, including the worst aspects of victimization. Like others, therapists may feel that the child has gone through something that is too horrible to talk about, or they may fear causing the child further harm by bringing up painful aspects of the event. The origin of the avoidance may be internal to the clinician rather than to the child. There may be an anxious need to contain affect in response to the child’s experience. The clinician may not want to hear, for example, the viciousness of a child’s revenge fantasy. Fear of not knowing what to do in the face of intense emotional pain may reinforce the avoidant bias.

If the clinician has had a previous traumatic or stressful experience, the child’s story may reecho the clinician’s own previous symptoms or intense emotions (see Chapter 2, this volume, for a discussion). The reemergence of the clinician’s symptomatic or emotional response may jeopardize her or his ability to take a therapeutic stance. For example, a school psychologist was unable to think about the traumatic deaths of two school children without remembering the traumatic death of her cousin when she was 12. She had difficulty sitting through training sessions regarding children’s traumatic responses. She was also concerned when her anxiety and distress interfered with her ability to assist the deceased children’s classmates and teachers with their reactions. In fact, some clinicians must eliminate themselves from treatment of the children altogether, because of their own experiences previous to or during the traumatic event. For example, the school psychologist who had been injured in war-related combat had to maintain a peripheral role in assisting children after a school shooting when he began to reexperience thoughts of the combat experience. After school children were killed, mutilated, and injured under the fallen bricks of a building, a psychologist who had been a part of the rescue effort found that hearing the children’s descriptions of their experiences increased her own symptomatic response.

Countertransference as a Form of Therapist Resistance

Some clinicians have expressed concerns about questioning children regarding their traumatic experiences even for the purposes of diagnostic screening. For example, in one war-torn country where the threat continued, a few clinicians became concerned about our protocol, which called for directly questioning the children. They first focused on ethical issues, then the length of the interview, then on peripheral issues such as concerns about transportation to sites and availability of children, then on the potential harm in asking children about their pain. It became clear in observing the clinicians, before and during practice interviews, that they felt protective toward the children both from overidentification with their pain and horror and from discomfort at watching the children suffer. As they became comfortable with the interview, they were pleased with the results of administering it. In fact, although the children sometimes cried or expressed other intense emotions such as anger during the interview, they were relieved, unburdened, and more animated after the interview. They smiled, skipped away, and thanked us. They told their friends about
the interview and the other children waited in line to talk with us. It can be a disservice to children to communicate, even nonverbally, (1) that it is too overwhelming to discuss the trauma, (2) that it is not okay to talk about their experiences, and/or (3) that they cannot discuss these intense experiences and still cope afterwards. It is therapeutic for children when the clinician recognizes the value of talking and recognizes in the child the strength and courage to endure and to process traumatic materials.

Moreover, especially during initial intervention interviews, any reluctance to directly discuss the child’s experience may lead to disturbances in memory and cognition related to the event. It is essential to elicit the whole of the child’s experience including her or his affective responses, rather than encouraging a journalistic retelling. It can be a countertransference to be unaware of affective constriction in the journalistic recounting, especially in latency age children. The child’s journalistic review of aspects of the event, in fact, may diminish understanding of the event’s meaning to the child and the particular way in which the child experienced traumatic helplessness.

Avoidance may occur in the form of collusion between the therapist, family, and child either not to address something that is important to the experience or to avoid or ignore clear links between the child’s behavior and some aspect of the event. Responsible adults may hesitate to tell the truth (sometimes out of a sense of protection) or, to the contrary, may give the child information beyond her or his ability to understand. For example, misleading explanations, conspiracies of silence, or prohibitions against discussion of certain details of the event can all contribute to chronic difficulties in cognition or to an inability to accurately identify emotional responses (Pynoo & Nader, 1988b). Because of a desire to believe that the event had no real effect on the child, adults may avoid linking aspects of the child’s behavior to a traumatic event. Effective clinicians recognize this avoidance in themselves and in the child’s adult caretakers, for example, when a grandmother, now guardian, whose son killed the child’s mother, finds it important to blame the mother and deny symptoms in the child. Moreover, the clinician may make the wrong link either in an attempt to make any link that presents itself or in order to avoid the more appropriate link, which might evoke an intense affective response.

### Directiveness

Our specialized methods are directive in nature. The degree of directiveness is, of course, adjusted to the tolerance and needs of the child. Countertransference tendencies may contribute to uncertainty, leading clini-

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Criers either to pull back or to plunge forward. Resistance leaves the child with the impression that aspects of the trauma are too horrible to face or that she or he is incapable of facing them. It lends inadequate support or energy to the child’s reprocessing or resolution of specific aspects of the event.

Combining a sense of uncertainty with attempts to help children recount even difficult moments may result in counterphobically pushing forward into traumatic materials. Although pushing forward is essential in this method of trauma work, counterphobically doing so fails to respect the child’s timing, limits, and needs. Failing to adjust the method to the child’s needs may cause further resistance or avoidance in the child or cause a sense of failure in processing the event.

Out of their own needs to restore a sense of safety or normalcy or to avoid the intensity of traumatic emotions, clinicians may revert to less directive methods of inquiry and more traditional formulations. Interpretations of traumatic behaviors based on early childhood conflicts or on non-trauma-related symbolic formulations may both avoid traumatic issues and increase the traumatized individual’s sense of aloneness and helplessness. For example, an adolescent patient reported to a psychiatrist that, in response to a traumatic reminder, she had been distressed and confused and had inadvertently entered the exit of the freeway. He looked for the symbolic meaning of entering the exit. This focus increased the girl’s distress rather than leading to any resolution. It ignored the intensity of her trauma-related regression, concentration impairment, and confusion, and it failed to lead to protecting her from driving when symptoms might interfere with her ability to do so safely.

### Intervention Fantasies during and after Traumatic Experience

Intervention fantasies are integral to the ongoing therapeutic processing of a child’s traumatic experience (Pynoo & Nader, 1989). These include the child’s or adolescent’s fantasies during and after the traumatic experience of preventing or stopping the harm, of confronting the perpetrator, of effecting repair, or of revenge or retaliation. For example, a 5-year-old boy fantasized running for help when he saw the man on top of his stepmother but, after being slammed onto the floor, the boy followed the rapist’s instructions to go back to sleep. A preadolescent imagined using his martial arts skills against the assailant. An adolescent ran for a knife to stab the attacker, was disarmed, and felt cowardly. Revenge fantasies against the trauma perpetrator may occur during or after the traumatic event as a desire to intervene or as a result of traumatic rage. Countertransference may result in seeing only the rage and in overlooking
the revenge fantasy’s specific link to the trauma. For example, a pre-adolescent boy witnessed the rape of his mother. He later entertained a fantasy of poking out the eyes of the rapist and putting a pencil up his penis. This fantasy of revenge was directly related to the visual insult of witnessing with horror while this man penetrated and ejaculated on his mother and to the boy’s desire not only to injure the offender but to prevent him from ever again harming someone in this manner.

Countertransference as a Source of Insight

The clinician responds to the child’s intervention fantasies with her or his own emotions of empathy or overempathy, identification or overidentification, and/or tolerance or worry about the intensity of the child’s emotions. The clinician, too, follows the story of what happened, which evokes her or his own countertransference fantasies of intervention. The clinician imagines what could have been done to prevent or stop the harm, how someone could have intervened, or the appropriate actions to take during and after the traumatic event to mitigate pain or injury. If clinicians excessively relate, for example, to the rage or anger, their timing may be affected. For example, a young woman’s closest surviving adolescent sister found her bloody body after the young woman shot herself in the head. The clinician who saw the surviving sister for treatment of her traumatic reaction felt drawn into an angry stance toward the deceased sister, in part, for traumatizing her patient (see case example later). She wanted to immediately address the patient’s anger at her sister. The focus was ill-timed, as the patient needed first to address her strong desire to assist and to repair the damage.

When a child’s desires to act are unresolved, the result can be a major change in behavior and personality. For example, lack of resolution of a revenge fantasy may result in increased aggression or inhibition (Nader & Pynoos, 1991). A 12-year-old boy was under a table for nearly an hour and a half while a sniper walked around the restaurant massacring 21 people and injuring many others. The boy was shot in both arms. He spent a portion of the time he was immobilized under the table entertaining fantasies of beating up the sniper. When a SWAT member, wearing the same clothes and boots as the assaulter, pulled him up by the arm, the boy tried to slug him thinking he was another assaulter. Later the boy became violent any time anyone put their hand around his arm, when he wore boots like the sniper, or when anyone touched him in the way he had touched his dead friend in an attempt to awaken him. He provoked physical fights with his peers and carried a weapon into an area known to be frequented by other armed adolescents. If, as a result of their own

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countertransference fantasies or affective reactions, clinicians ignore or censor fantasies of intervention, or attend to them in a manner that is ill-timed or inappropriate to the child’s needs, the child’s resolution of these desires to act may be thwarted.

Anger and Impulse Control

Clinicians may oversympathize or overprotect when issues of anger and impulse control arise. Traumatic exposure challenges a child’s sense of impulse control (Pynoos & Nader, 1988c). The oversympathetic clinician may find her or his own resolve undermined. For example, some children begin to wonder why they should bother to behave, if bad things can happen to you anyway. After a tornado killed nine children in one school, one teacher described that children acted as though they no longer knew the rules. When told that they had to behave appropriately some of the children asked, “Why should we?” Recognizing the child’s (and others’) need for structure, for a return to normalcy, and for a reduction in the post-trauma chaos, the clinician is able to assist adults in the child’s world in responding.

Seeing an adult react violently during a violent event can make a child question her or his own ability to control herself or himself. Lapses in self-control may take the form of reenactment or traumatic play. One little boy whose father had strangled his stepmother began to play at strangling his peers, sometimes frightening them and causing them pain. Other than to prevent harm, both guardian and clinician in a countertransference may decide to overlook lapses in control because lapses are understandable after a traumatic experience or because the children should not be punished when they already feel so bad. Paradoxically the resultant absence of structure or control may be frightening to the child who, especially after the trauma, needs limits to regain self-control, a more normal sense of self, and a sense of safety.

Traumatic rage may further challenge a child’s impulse control. When the lack of impulse control is amplified by the child’s expression of traumatic rage, it may cause concern in the therapist. A clinician who already has difficulty with anger or rage may find the presence and expression of rage difficult to tolerate and may censor this effort of the child to manage the trauma. Even the clinician who tolerates anger may become concerned at the intensity and implications of its expression in a traumatized child, especially when there is repetitive aggressive play. A 10-year-old boy who had been injured twice by falling (once from his high chair; once from a second-story window) was referred for “strange” behaviors at school including head banging and poking himself with a pencil. He
played regularly that toy soldiers, ninja turtles, and stuffed animals beat each other to death. When he told stories, the main character kept accidentally killing people. The therapist identified with the innocent victims in the play and thus failed to understand that it was the child who was the victim and that the accidental killer was the mother who had failed to prevent the boy's falls. The clinician became concerned that he was working with a budding serial murderer and had a desire to change the play and story endings so that the aggression was stopped or the aggressor transformed.

Censoring the child's expression of rage or revenge may create rather than solve the problem. On the other hand, the clinician wants to avoid desensitizing the child to causing pain or harm. The idea is to facilitate the expression of rage or revenge in the safe therapeutic setting while reinforcing the child's impulse control. When successfully accomplished, the result is a sense of relief, a reduced sense of helplessness, and freedom to examine the other aspects of the traumatic experience.

The Phasic Nature of Trauma Recovery and the Timing of Interventions

Trauma recovery is characterized by progress alternating with periodic exacerbation of symptoms. The child lends meaning to specific traumatic moments and puts them in the context of her or his life. The exacerbation of symptoms may elicit in the therapist guilt, a sense of self-doubt, or even a sense that the original assessment of progress was inaccurate. Fears of not helping the child or making her or him worse may result. These symptom exacerbations can be a dangerous time for the patients, who may also fear that they assessed their progress inaccurately or wrongly trusted the treatment and are not really getting better. Feelings of depression and sometimes suicidal ideation may increase at this time. Thus the patient's and the clinician's fears reinforce each other. Understanding the phasic nature of recovery and identifying the countertransference fear of harming prepares the clinician to appropriately label for the patient these predictable moments.

Also, during the course of recovery, there may be a reduction in numbing and a complementary exacerbation of intrusive symptoms. This increase in symptoms can be recognized as a sign of progress, rather than a failure of treatment, and as an indication that further exploration of specific moments is necessary. Unburdened of the countertransference fear of hurting the child, the clinician is able to respect the child's own timing. Initially, even though, for example, the clinician perceives that the child's first identified "worst moment" is less severe than other aspects of her or his experience, it may be more appropriate for the child to address the less trying moment first. For example, an 11-year-old girl was hit in the face by a flying table during a natural disaster. Her front teeth were knocked out, and she bled profusely. When asked about her worst moment she focused on a true moment of fear—calling for help after the injury, when the debris had stopped flying; the desperate need for rescue. Both initially and as numbing reduces and the child's confidence and ego strength improve, it is essential to push through difficult moments, to find the physiological, affective, and perceptual aspects of the experience, as well as any lost portions. Indeed, the aspects of the traumatic experience originally defined by the child as the worst moment may pale in comparison to what she or he is later able to face. On the other hand, the child's first identified worst moment may be psychodynamically more important to the child, and thus may be, for the child, the worst moment. For example, a school-age girl described being called by her nickname by her father before he shot her.

Moreover, each child establishes her or his own rhythms of trauma review. For example, Randy, the adolescent who was injured during a massacre in a fast-food restaurant, came late to trauma treatment. He engaged in trauma work only every other session in the initial phases of his trauma work. Early in his treatment this adolescent engaged in symbolic trauma-related activities for a portion of each trauma-focused session as well as in discussion of the trauma (e.g., waging war on the ants outside the therapy room after discussing the death of his friend during the massacre). A girl who was the sole survivor of the kidnap and murders of her family needed to focus on the loss of her family about every fourth session, after she mastered specific traumatic moments and issues. Some children need periodically to stop and focus on secondary post-trauma changes to their lives or on the meaning of the trauma to previous or subsequent life experiences. The clinician's own comfort and confidence assists recognition of and attunement with the child's particular rhythm.

A child may redefine individual traumatic moments/experiences or her or his own response to them. As a result, trauma work involves re-review and/or a more thorough review of specific traumatic moments or moment complexes with thorough attention to the new issues, definitions, responses, and/or the deeper meanings of the experience. The clinician must be willing to re-review aspects of the event in search of the child's reprocessing. For example, a change in the child's intervention fantasies or resolution of specific issues may permit the child's deeper focus on certain details. For example, an adolescent girl, her mother, and brother were stabbed by her father. The girl was unable to recall the frightening look of intent on her father's face, his raising his arm to stab her, or his cutting her hands and face. She could not admit his murderous
intent, her sense of betrayal, or her anger until she was certain that she would not lose him. The need for repetitive reexamination of aspects of the event may elicit the clinician's own avoidance of seeking their more difficult meanings for the child.

**TRAUMA'S COMMON THEMES**

Some level of emotion is naturally elicited in response to the child's story. Common traumatic emotions include helplessness, rage, revenge, hopelessness, horror, avoidance (especially with ongoing or repetitive trauma), regressive states, and fear. The therapist's own past experiences may have rendered her or him vulnerable to common traumatic emotions. Some traumatic emotions are contagious (e.g., fear), are common responses (e.g., anger that this could happen to a child or about issues of accountability), or are distressing because of their intensity (e.g., traumatic rage or helplessness). Even seasoned clinicians may feel ineffectual in response to a child's sense of helplessness or overwhelmed by a child's rage or the viciousness of the child's revenge fantasy. The clinician's knowledge that clinician and child are not helpless in this moment and observation of enough recovery from traumatic response to know that there is hope can aid both patient and clinician.

The therapist's own expectations and responses related to the event can interfere with the ability to facilitate the child's psychic integration of the event and/or of a traumatic loss. Specific attitudes may undermine the clinician's therapeutic stance or inhibit therapeutic action. We have different clinicians treating parents and children. The clinician treating the mother influences the care of the children. One resident felt that an injured mother would never be able to recover from the psychological wounds inflicted by her husband's attack. He was certain that the woman would never again be capable of a normal relationship with a man. This attitude left the resident with a sense of helplessness about the ability to effect healing after this trauma. One child psychiatry fellow reminisced about his own loss and had difficulty focusing on the child's loss of a parent. Attitudes toward dependence and rage, which are frequent components of traumatic response, must also be examined. The clinician may, for a limited time, encourage dependence and may find it important to facilitate the expression of rage and revenge fantasies while reinforcing impulse control and rational decision making.

The clinician engages in play with the traumatized child and may become the object of his traumatic emotions. One child who had undergone catastrophic treatment for cancer delighted in repeatedly mutilating and killing the clinician (Nader, Stuber & Pynoos, 1991). As discussed earlier, appropriately facilitating these fantasies of revenge becomes a part of the therapeutic process. Children take any of several roles in response to traumatic experience. The therapist must be comfortable being assigned by the child any of the several roles, for example, victim, aggressor, rescuer, witness, external conscience. Marielle became nurse to the clinician who acted as victim. Abdul punched the therapist in the cushion protecting his abdomen while pretending the clinician was the bad soldier who tried to rape him. Randy (injured in the fast-food restaurant massacre) carefully positioned the clinician to the side to silently watch as an external conscience while he played sniper in the wooded area near the hospital clinical rooms.

Children commonly exhibit changes in school behavior and cognitive performance. A child's fear of stigmatization or self-consciousness about physical or emotional symptoms may result in school avoidance. The clinician may need to respond to very complicated issues of reentry into school. The therapist may need to come to grips with her or his own sense of helplessness or revulsion with regard to the child's injuries, deformities, or disabilities. There may be a sense of guilt, a sense of helplessness or ineffectualness to repair the child or her or his damaged self-image, or a sense of disaste or fear at seeing that someone normal can be made handicapped. As a result, the clinician may be reluctant to push the child forward through review of difficult moments or may reinforce the child's own sense of damage.

The child or adult exposed to trauma may lose appropriate judgment about maintaining her or his own safety. This may be, for example, a result of trying to overcome traumatic fear, an indication of unresolved rage or revenge fantasies, or a form of reenactment behavior. After running from gunfire during a sniper attack, a 7-year-old girl began walking into alleys frequented by drunken men, misjudging when to stop in the street, or freezing in the street with a car coming. Recognizing this phenomena, it is important that the clinician avoid overidentification with the need to master fear and, thus, avoid pushing the child to overcome fears prematurely. Further, it can be trying for the clinician to be working with a child who is, for example, walking into alleys or carrying weapons into areas where there are other armed youths. It is essential for the clinician to maintain for herself or himself as well as for the child a realistic evaluation of danger and a need to protect from secondary harm.

Trauma victims often feel compelled to share their experience. For example, after a wartime experience, adults repetitively reviewed videos and pictures of the horrors and children repetitively replayed aspects of the event. The clinician may be asked to view pictures of mutilation and to see destruction. In one war-torn country, before dinner pictures were passed around of horrible mutilation, burned bodies, and rudely ampu-
tated body parts. The consultant was taken to see the instruments of torture and bloodied manikins depicting their use. The clinician may need to protect herself or himself as well as children from these secondary trauma.

Issues of Accountability

Issues of accountability may elicit a variety of countertransference responses in the clinician. Deaths during a disaster have been attributed, for example, to architectural defects, to caretakers ignoring the directive to evacuate, or to lack of proposed repair to at-risk buildings or bridges. In cases of violence, someone has intentionally threatened, endangered, or harmed others. Even with accidental death or injury, issues of culpability arise. The clinician may respond with anger, despair, or horror at the nature and results of the neglect, harmful intent, carelessness, or recklessness. Like others, in the absence of a clearly identified perpetrator of the harm, the clinician may consciously or unconsciously look for someone to blame for the victimization of children. These responses may jeopardize the clinician's therapeutic stance.

When the child has a preexisting relationship with the perpetrator of harm, a tension occurs between the need to facilitate traumatic response (e.g., rage, disappointment, fears related to identification) and the need to respect the child's relationship with the individual (e.g., issues of identification, attachment, loyalty). We have found it helpful to allow the child to begin to address traumatic issues as though from the third person (“If someone was angry at your father for what he did, what might they want to do to him?”) or once removed (“If you were angry at your father...” or “If it was someone else who had done this, what do you think should happen to them for what they did?”).

Different Agendas: The Traumatized Family System

The ability to remain neutral and to avoid overidentification with only one family member is essential to the trauma specialist. Following traumatic events, each family member may have different psychological agendas according to preexisting relationships, exposure, and subsequent impact. When there is work with individual children and parents after a traumatic event, these different agendas must be appreciated. In situations of mass trauma where there have been deaths, the intervention process can become complicated as there are those who are traumatized who did not know the deceased, those who are suffering traumatic grief without

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traumatic exposure, and those who are both grieving and traumatized. Each group has its own agendas and phases of recovery. Trauma therapists may find themselves caught between the need to protect the traumatized children from inundation with inescapable reminders of the event and the grieving parents' needs to have tributes to and reminders of their suddenly lost children. After a disaster at a school, there may be many proposals for memorials. Compassion for or identification with grieving parents may make it difficult to set appropriate limits on the number of memorials.

Clinicians may find it difficult to remain neutral or may overidentify with individual family members. In a family in which the father was unable to protect his wife and daughters from robbers, an 11-year-old girl weekly expressed, in her play, her anger and disappointment at her father's ineffectualness. The entire family's upset with the father kept the family divided and unable to provide adequate support for each other. Clinicians found it difficult to remain unaligned with the mother against the father, who was urging the cessation of treatment. The father was in an occupation in which he dealt with life and death situations. In his uneasy lack of ability to prevent this harm, the father insisted that no one was really badly hurt (there was a severe knife wound and a molestation that occurred during the robbery). Counterphobically, he left doors unlocked at night to the complete distress of his family and the empathic concern of the clinicians.

The 11-year-old girl's clinician counteracted the temptation to align with the mother by searching for a method to restore family cohesion and mutual support. One of the goals of treatment was to help the child to understand that the father's behavior was rooted in his difficulty with accepting that he was unable to protect his family. With children especially, there is often ample opportunity to stay within or to facilitate the child's metaphor in addressing traumatic issues. With this family, it permitted constructive interventions that met the needs of the entire family. In a subsequent session, the child drew a picture of a sun with the measles (clearly a representation of the father) that could not be treated because it was too big and too sick and you could not get close to it or you would get burned or catch the illness. The discussion that followed permitted the child to first send medication to the sun (father) from afar via spaceship and then to recall what one might do to help someone sick to become well. The father began locking the doors shortly after this session and stopped asking the mother to cease bringing the child to treatment.

**THE THERAPIST'S EXPANDED ROLE**

In working with traumatic responses, the therapist's role expands from individual work to include assistance within the family and community.
(Nader & Pynoos, 1988; Pynoos & Nader, 1988a). Clinician resistance or a sense of being overwhelmed may result or may increase in response to the number and locations of interventions needed. The therapist may need to relinquish ideas of treatment’s confinement to the office, or she or he might need to make provision that other areas are given ample attention.

The therapist’s role becomes that of advocate when dealing with some of the secondary stresses following a traumatic event. In the immediate aftermath of the event, children need protection from unnecessary reexposure to, for example, the sights of death, injury, or mutilation. Inappropriate media coverage, such as exhibiting corpses or mutilated bodies, or courtroom pictures taken in evidence may also have a harmful effect.

Family interventions may be necessary. Family members may be very unfamiliar with the nature of post-traumatic symptomatology, its appearance, course, and meaning. Parent education necessitated by exposure to adverse life events includes more than helping the parent to understand expectable emotional and behavioral changes. In addition, the clinician may need to assist the parent in creating an atmosphere conducive to open communication, to reestablish a sense of safety, to tolerate time-limited regressions, to identify and anticipate traumatic reminders, to observe traumatic behaviors, and to expect the phasic nature of recovery.

Providing a therapeutic atmosphere at home requires that parents, guardians, and siblings first work toward resolution of their own responses to the event and any loss of life or property. The clinician may provide brief interventions with other family members or make referrals for treatment. Randy’s mother experienced intense guilt feelings for not keeping him from harm and later for not knowing that he needed early specialized intervention. As a result, she had difficulty holding Randy accountable for his behavior, which added to his difficulties with impulse control.

Loss of a sense of safety and issues about the lack of absence of adult protection are common to traumatic exposure. Lack of trust may be transferred to the clinician, especially by children with repetitive trauma or physical injury. It may be necessary to adjust pace and style for these children. Clinicians need to monitor a sense of disillusionment, irritability, or guilt in themselves resulting from the lack of an immediate connection with the child. The clinician may develop a sense of inadequacy with the trauma work or an attitude that the child is irreparable. Moreover, the clinician may become aware of her or his own issues about her or his ability to provide protection. Children with badly damaged trust will take longer to establish trust and will present differently than other children do in their initial trauma interviews.

It may be necessary to assist the child with changes in social inter-

acting following traumatic experiences. Children can be helped to courteously decline to discuss the event with peers. Children have described renewed traumatic emotions when asked about the event. Some of the same children have felt stigmatized or disappointed in the lack of understanding when they have tried to share their experiences. Randy was called a liar and ridiculed when he said that he was in a massacre. Preoccupations with aspects of the trauma, changes in outlook, increased irritability, and other traumatic symptoms may affect peer relationships and may require assistance in maintaining peer support.

If the event occurred at the school, the school itself may become a traumatic reminder and its smooth functioning may be disrupted. Moreover, clinicians may be required to assist when the children are faced with teachers or other school personnel who react with upset to traumatic reminders. After a school shooting, one staff member began to confiscate toy guns or pictures and became frantic when there were bleeding children (the number of whom seemed to increase in the months following the event at the school). Because the alarm had been activated to get the children away from the site, most of the teachers and many of the students reacted the first few times it went off. School administrators can be helped to anticipate these reminders and to prepare the staff and children. The therapist may need to assist an injured child back into the classroom. A classroom visit and exercise, contacts with teachers and school counselors, preparation of the child and parent for the classroom discussion, and/or a graduated curriculum may be necessary.

If the child is a witness to the event, court testimony may be necessary. The child’s emotional response during review of the event may incapacitate her or him as witness. It has been effective to work with children in reviewing the traumatic event prior to the testimony and to be present for the testimony. In addition to preparation for testimony, children are prepared for their subjective responses to recounting. In one kidnap and murder case, a special attorney was appointed on the child’s behalf and he saw to it that the therapist was permitted to sit next to her when the child took the stand.

The clinician may feel confused or helpless at the hands of the court system or in attempting to understand the legalities of the case. It is essential but not always easy to gather the knowledge needed. In one case, a father stabbed his wife and two children. The mother became caught between wanting justice and protection for herself and her children and not wanting to do further harm to her suicidally depressed husband. Confusion about the legalities of providing this protection and a sense of needing to advise the mother led the clinician feeling ineffectual. The therapist’s intense need to protect the mother from further harm resulted in overprotectiveness and overinvolvement in the woman’s life. It inter-
fered with the clinician’s enabling the mother to handle these moments more independently and competently herself.

Ongoing Work with Trauma Cases

With a steady dose of trauma cases, the therapist requires ample debriefing and sufficient self-care to recover from the potential drain and to gain a sense of relief. A possible result of the therapist’s inadequate self-care is premature termination of cases. This can occur, for example, because the therapist becomes less thorough in discovering and exploring the individual emotion-laden moments of the child’s experience.

Fatigue from the intensity of trauma cases, the lack of thoroughness itself, overallowance of avoidance, and other concomitants of trauma work can produce an apparent boredom or a confusion over what is left to do. This attitude can affect the energy available from the child and the therapist to face, at a new level, the difficult traumatic moments. Like the child, the therapist may desire to step away from the impact on the child. The child and therapist no longer desire to bring the trauma and trauma-related emotions home with them.

Case Example: Sandy

In her first trauma therapy with an adolescent, Dr. J. found it difficult to listen to the following trauma story from her adolescent patient: Sandy returned home from a family gathering to find her sister, Rita, in the bathtub bleeding from head and nose, convulsing, and drooling bloody mucus from her nose and mouth. Sandy tried to talk and comfort her. She agonized over where the wound was and what to do to stop the bleeding. Rita attempted futilely to communicate with one of her hands. Sandy telephoned the paramedics and returned to her sister’s side, but Rita was dead on arrival at the local hospital.

Sandy described herself as “like her father, emotionally avoidant and the family caretaker” before Rita’s suicide. After the suicide, these coping mechanisms became even more pronounced. In general, Dr. J. worked well with Sandy over a period of 1 year before Sandy relocated. Dr. J. established an excellent rapport and created a safe environment in which Sandy could review her horrible experience and could discuss what she thought were embarrassing fears and other emotions. The treatment was a challenging and stressful one for Dr. J. and its initial phase was difficult.

There were important parallels between Sandy’s trauma and Dr. J’s own life experience. At age 11, Dr. J. traumatically discovered her own mother “unconscious, limp, and eyes open” after a suicide attempt and saw her whisked to the hospital. She had concluded that living with her extremely rational, emotionally avoidant father was a toxic environment for her mother and an important source of her suicide attempt.

Partly because of her own experience, Dr. J. identified with Sandy’s helplessness in the face of suicidal tragedy. She empathized with Sandy’s feeling “stuck forever” with this traumatic memory and her loss of a sense of normalcy. “It [the traumatic experience] really is a loss of the illusion of safety.” She was also quick to recognize Sandy’s adaptive response: “What a good girl” Sandy was. “She never intrudes.” Dr. J. worried that she was somehow prohibiting Sandy’s expression of anger, as she had prohibited her own in order to cope with her mother’s suicide attempt.

Recognizing the risk to Sandy because of her sister’s suicide, Dr. J., as in childhood, would need to prevent a suicide attempt by Sandy. To add to her concern, Sandy’s environment promoted an identification of Sandy with her dead sister. People called Sandy “Rita” or addressed her as “the sister of the girl who had killed herself.” Her family members wanted her to wear her dead sister’s old clothes and sometimes seemed to want her to replace her sister. Dr. J. felt that the emotionally avoidant, toxic atmosphere at home paralleled that of Dr. J.’s mother; Dr. J.’s countertransference tendency was to be protector. Dr. J. explained that craziness/suicidalness is inside all of us. Sandy’s circumstances had made Sandy aware of her suicidal thoughts. Dr. J. next tried to intervene preventively. She called Sandy’s father and told him to lock up his guns and separate the ammunition from the guns. Dr. J. wanted to show Sandy an article on the dangers of handguns. She wanted to reassure her that it was her family that was pathological for having handguns in the house, not that she was crazy. She was tempted to tell Sandy about her own mother’s suicide. Talking it over in supervision, she decided that telling Sandy would focus attention upon Dr. J. and off Sandy, so she refrained.

Dr. J. continued to “reach out to her more and rescue her from her pain and sadness. Wanted just to whisk away her distress.” Dr. J.’s protecting and rescuing impulses served a resistant function resulting in avoiding the details of the trauma. She wished to “leave this poor girl’s trauma alone,” and to work only on the mourning. She resisted facing the horror of what had happened. She preferred to calm Sandy and to “melt away” the sense of abnormality so “at least in the treatment session she could have felt normal.” When Dr. J. could fully listen to an in-depth retelling of the trauma story, she was impressed with how powerful Sandy’s imagery was. She discovered that the details were clarifying rather than horrifying.
In order to endure the trauma review, Dr. J. consciously said to herself, “It is not my mother who died. It isn’t me experiencing these horrible symptoms.” She did this “to protect [herself] from the intensity of [her] own frightening emotional responses.” She initially resisted facing and re-reviewing with Sandy emotion-laden moments. She first seemed to use traditional listening and interpreting methods as an avoidance of pushing Sandy to thoroughly review her experience. Now, she wanted to hear everything and “recognized that this is where Sandy’s environment [and her own as a child] had failed.” She remembered having no one to talk to after her mother’s suicide attempt—being frightened, lost, and alone. Her own father never talked with her or her mother. Dr. J. could now hear other differences from her own trauma.

Sandy’s father had been a “provider—he lived at the office,” but after the suicide her father put his arm around Sandy and said, “I’ve been a bad father.” He began wearing his dead daughter’s earring as a tie tack. Sandy was uncomfortable with this new display of affection and attachment from a man who previously was nonemotional.

Two weeks before the suicide, Rita had been lying on a table at a party with a knife saying she wanted to kill herself. No clinician was consulted because this was a good Catholic family with no mental health problems. Dr. J. saw Sandy’s family as wealthy and hypocritical, as preferring to imagine they lived in a perfect world rather than to accept the fact that their daughter lying on a table with a knife indicated a troubled world. Had they really listened to their daughter and not maintained this false image, Dr. J. felt, they could have prevented the tragedy.

Rita had called Sandy at 2 A.M. to talk 3 or 4 days before the suicide. Sandy had been too tired to really talk at that time of night and remained unconsciously guilty that she failed to prevent the suicide. Listening to this preamble to the suicide, Dr. J. was annoyed that nothing was done to intervene and blamed it upon the family’s value system. She imagined intervening at the party, where she would take Rita immediately to the emergency room, thereby obtaining intervention and averting the tragedy. She also entertained the intervention fantasy of going into the home after the initial warning and removing all of the guns. Dr. J.’s attitude toward the family initially interfered with her understanding Sandy’s intervention fantasy, namely, that she prevent the suicide by listening differently to the 2:00 A.M. phone call.

Sandy was on a different emotional time schedule in her grieving and trauma resolution than her family. While she was attending to trauma issues, they were mourning their loss. Sandy’s mother had been putting flowers on her daughter’s grave many times per week. Sandy kept telling her mother, “Sis is dead, she’s dead” in an attempt to stop this behavior.

Dr. J., in a fantasy, envisioned the two taking each other into the other’s arms and comforting one another. She wished they could all reach the same phase so that they could return to being a normal, loving family and so that her patient could receive the familial support that she needed.

Soon Sandy’s increased risk-taking and other reenactment behaviors put Dr. J.’s intervention fantasies to the test. Sandy reported driving fast down mountains and jumping over cliffs during hiking. She wondered out loud what it must have felt like for Rita to die. Unconsciously identifying with her suicidal sister, she placed Dr. J. in her own role of trying to prevent Rita’s death. At one point, she “slashed her wrist” (Sandy’s words) accidentally when she dropped some industrial-strength plastic wrap while waitressing. She bled profusely but remained totally calm while everyone else became hysterical and rushed around. She, in fact, calmly took control of the situation to see the accident did not become a tragedy. She gave her fellow workers instructions on how to stop the bleeding and to get her to the hospital for stitches. Unlike Rita, Sandy chose a course of survival. Dr. J. said that Sandy chose to be competent in the face of the trauma even though Dr. J. remained concerned that “she had to slash her wrist in order to do it.” Sandy now realized that she had tried her best with her sister, although she felt very guilty at her lack of success. Dr. J. noted that the treatment was moving to a new level. She felt both empathic and competent.

Sandy underwent a reduction in numbing and an exacerbation of symptoms following attending a play about suicide. She graphically described to Dr. J. her experience. Her leg began to shake as it had during the attempt to comfort and get help for her sister. While she watched the fake blood on the suicide victim in the play, she recalled the stickiness of her sister’s blood and felt stickiness on her perspiring hands. She felt a renewal of traumatic anxiety and revulsion and experienced flashback imagery. Her heart was racing, and her respirations quickened. After viewing this play, these and other symptoms increased. It helped a great deal to tell Sandy what was normal so that she could tolerate her symptoms. Dr. J. used the increase in symptoms successfully to enhance Sandy’s ability to explore the symptoms and traumatic material.

After successfully facing some of the traumatic issues, Sandy began to grieve the loss of her sister. She felt sorrow over things her sister would never experience. While on a water mattress on the ocean, she felt the warmth of the water droplets on her skin. She realized her sister would never experience this again. Dr. J. empathized with the sense of loss and found herself regretting this with her patient. She focused on the fact that Sandy had more sympathy and appreciation for life now that she had successfully processed much of her traumatic response.
RECOMMENDATIONS

Trauma work can be both stressful and rewarding. The following are several ways in which clinicians can prepare themselves for the difficulties of trauma work:

1. Become well informed about the trauma.
2. Engage in debriefing regarding the event.
3. Engage in ongoing, adequate self-care (e.g., rest, recreation, support, debriefing, reprocessing, self-pampering).
4. Regularly examine responses, resistances, and tensions related to trauma materials.
5. Develop a willingness to hear anything.
6. Be prepared to move a child forward through a review of horrible moments and emotions with a sensitivity to the child’s timing and tolerance and a recognition of and respect for the child’s ability to face and cope with the trying aspects of her or his experience.
7. Recognize the phasic nature of trauma recovery and the need for occasional “time-outs” from direct traumatic focus.

Countertransference issues change with the type and duration of treatment (e.g., consultations; individual or group interventions; brief or long-term treatment). This chapter has focused primarily on issues of acute phase and brief individual interventions. Over time, issues become focused in the transference.

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