Encyclopedia of Trauma: An Interdisciplinary Guide

Shared Trauma

Contributors: **Author:**Carol Tosone
Edited by: Charles R. Figley
Book Title: Encyclopedia of Trauma: An Interdisciplinary Guide
Chapter Title: "Shared Trauma"
Pub. Date: 2012
Access Date: March 18, 2021
Publishing Company: SAGE Publications, Inc.
City: Thousand Oaks
Print ISBN: 9781412978798
Online ISBN: 9781452218595
DOI: http://dx.doi.org/10.4135/9781452218595.n214
Print pages: 625-627

Several terms have been forwarded in the mental health literature to describe the deleterious effects of working with trauma survivors, including burnout, compassion fatigue, secondary trauma, and vicarious traumatization. Although each makes a distinct and crucial contribution, these concepts describe similar symptomatology and address secondary exposure to patients' traumatic content. With the advent of worldwide terrorism and an increase in natural and human-made disasters, helping professionals may find themselves exposed to trauma primarily as citizens and secondarily through the trauma narratives of their clients, thereby necessitating an explanatory framework that captures the entirety of their experience. For these clinicians and first responders living and practicing in a traumatogenic environment, existing terms do not adequately convey the complicated nature of their multimodal reactions given that they have been exposed to the same collective trauma as their clients. In response to the attacks of 9/11 and the subsequent call for a more exacting construct to describe the ramifications of the clinicians' direct and indirect exposure to collective trauma, the term shared trauma was introduced into the professional literature. This entry defines shared trauma and discusses the impact of experiencing shared trauma on clinicians' personal and professional lives.

Definition and Distinguishing Features

Shared trauma, also referred to as shared traumatic reality and simultaneous trauma, is defined as the affective, behavioral, cognitive, spiritual, and multimodal responses that mental health professionals experience as a result of primary and secondary exposure to the same collective trauma as their clients. As with vicarious traumatization, these reactions have the potential to lead to permanent alterations in the clinician's existing mental schema and worldviews—the difference being that having experienced the trauma primarily, these clinicians are potentially more susceptible to posttraumatic stress, the blurring of professional and personal boundaries, and increased self-disclosure in the therapeutic encounter. Similarly, clinicians experiencing shared trauma may resemble those faced with compassion fatigue or secondary trauma in symptomatology; that is, multimodal and common symptoms such as exhaustion, depletion of empathy, and identification with the client may be similar, but are attributed to the dual nature of the trauma. The use of the term shared trauma, however, does not imply that the clinician's trauma response was identical to that of the client; clinicians and clients can be variably affected by the same simultaneous event.

Depending on the nature, intensity, extensiveness, and time frame (chronic vs. acute) of the shared trauma, the clinician can respond professionally and personally in myriad ways, with each area affecting the others. For instance, an Israeli clinician exposed to chronic acts of terrorism might be preoccupied with the safety of her family and have difficulty concentrating on client care, whereas a New Orleans practitioner might seek respite from personal Hurricane Katrina–related problems by overinvolvement in her clinical work and overidentification with particular clients. Israeli authors living and practicing in the terror-prone region near the Gaza Strip prefer the term shared traumatic reality because it encompasses the wider traumatic reality that clinicians and clients living and working in the affected community are exposed to on a daily basis; the emphasis is on the chronic traumatic impact on interpersonal and communal levels. Although shared traumatic reality has similar features to shared trauma, the latter is the more commonly employed term used to describe the impact of single catastrophic events in relation to individual client-clinician situations, as well as to the general therapeutic process and larger mental health community. Hurricane Katrina and the attacks of 9/11 are prime examples of these acute, singular disastrous events.

In addition to the factors already mentioned, the organizational context of practice in which the shared trauma occurs can also affect the clinician's responses. The perceived level of support available to clinicians from their professional and educational organizations, agency-based work settings, supervisors, and colleagues, coupled with the personal support they receive from family and friends, can also influence their personal responses to shared trauma and the quality of their professional work. All things being equal personally, a clinician in an agency-based setting with a supportive supervisor and colleagues, and an organizational structure receptive to employee input might respond more positively than would a solo practitioner without collegial support or strong professional affiliation. Student clinicians practicing in a shared trauma environment have reported that instructor guidance and supervisory support bolstered their confidence when seeing clients and helped them appreciate the symmetry of therapeutic work under these circumstances.

Clinical Implications

Shared trauma is consonant with the relational approach to treatment that emphasizes the mutuality of influence and affect regulation in the therapeutic dyad. Each dyad takes place in a unique, intersubjective context, specific to the particular client-clinician pair, their individual histories, current interpersonal realities, and distinct transference-countertransference matrix generated as a result of their interactions. As such, there is potential for mutual emotional contagion in that the subjective experience of self can be attributed to the other, and rather than helping clients process the traumatic event, clinicians may find themselves overwhelmed emotionally and enacting some aspect of the trauma. Clinicians experiencing shared trauma are deprived of the clinical distance usually afforded them by having a different set of external experiences than that of the client. A clinician primarily exposed to a collective disaster working with a client similarly affected may identify strongly with the client's horrific experience, and in an effort to convey empathy, might self-disclose her or his own disturbing narrative, further traumatizing the client. The clinician could also offer the client an interpretation better suited to the clinician's own situation than that of the client. Such an intervention contradicts a basic tenant of psychotherapy practice: Do not assume that one's experience is the same as that of the client.

Another aspect of shared trauma is its impact, both positive and negative, on clinicians' personal lives as a result of interacting with clients. Along with their clients, clinicians might find themselves bracing for another major disaster and being vigilant to cues that are associated with the trauma. Also, upon hearing a client talk about the loss of her husband in a collective disaster, a clinician might find herself having difficulty separating her own personal life from that of the client, as if the clinician too had lost her husband, and react similarly. The blurring of boundaries can lead clinicians to be engrossed in their clients' lives to the detriment of their own, but it can also make them more mindful of their loved ones and more protective of their personal time.

Opportunities for Personal and Professional Growth

Although shared trauma can have deleterious effects on the treatment process, clinicians have also reported positive personal and professional post-traumatic changes. In the personal realm, clinicians have reported the importance of spending increased time with family members, being more expressive of their feelings and more spontaneous in their actions, and experiencing greater intimacy with others in their personal lives. Professionally, there can be an increased sense of purpose and commitment to their chosen career, a renewed appreciation for the benefits and limits of the mental health profession, an enhanced need for political action and policy advocacy, and a greater capacity for empathy and therapeutic intimacy as a result of being exposed to the same collective trauma as their clients. Additionally, clinicians have reported being better able to manage their job responsibilities to achieve a more desirable personal-work balance, and to enjoy working with their clients more fully.

Recommendations for the Treatment of Shared Trauma

Shared trauma is experienced on many levels—intrapsychic, interpersonal, community, and societal—and individual intervention needs to consider these multiple facets. Assessment needs to consider those clinicians most at risk: those in close proximity to the disaster, those with increased disaster exposure as a result of voluntary experience or high caseload, those with a history of traumatic life events and insecure attachment, and those who are highly empathic or are neophyte practitioners. Also important is the clinician's level of perceived support from family members, colleagues, supervisors, and professional institutions.

The treatment provider needs to be aware of countertransference reactions when treating a fellow professional to ensure the integrity of boundaries, and to provide a supportive setting in which the person can recount his or her trauma narrative and its effect on his or her personal life and client work. Symptoms of posttraumatic stress are commonplace, as are feelings of guilt related to the need to take care of one's self and family before attending to the needs of clients. A therapist client who is too overwhelmed emotionally to work needs to be supported in that decision. Another, yet very different, response is the therapist client who avoids addressing the emotional effects of the trauma by devoting long hours to disaster-related work. In this case, the provider needs to help the therapist client understand her or his own response and the motivation

for avoiding self-exploration in favor of immersion into work. In both situations, the provider needs to help the person prioritize personal needs over professional activities, and in doing so, the therapist client can better access the emotional sustenance necessary to conduct stressful clinical work.

Social and professional support is important in mitigating the negative effects of shared trauma, so the person should be encouraged to access all sources available to her or him, including organizational resources. Private, agency-based, and peer supervision can be valuable sources of support. Therapist clinicians can also be encouraged to advocate for changes in their work settings, educational institutions, and professional associations to make these organizations more responsive to the training and peer support needs of clinicians affected by collective trauma.

Summary and Conclusions

Shared trauma is the multimodal response of clinicians who have been exposed to a collective disaster, both through personal experience and through the trauma narratives of their clients. It contains aspects of posttraumatic and secondary trauma stress, has manifestations in the clinician's personal life and professional life, and can lead to permanent alterations, both positive and negative, in the clinician's self schema and worldview. Therapy, trauma training, and supervision, as well as personal and professional support, can help alleviate symptoms and potentially lead to posttraumatic growth.

- trauma
- clients
- secondary trauma
- disasters
- personal life
- compassion fatigue
- empathy

Carol Tosone
http://dx.doi.org/10.4135/9781452218595.n214
See Also

- Bearing Witness to Trauma
- Growth, Posttraumatic
- Trauma and Social Work Practice
- Trauma Caregivers
- Traumatized Practitioners, Supervisors of
- Vicarious Trauma

Further Readings

Altman, N., & Davies, J. M. (2002). Out of the blue: Reflections on shared trauma. Psychoanalytic Dialogues, 12(3), 359–360.
American Psychological Association (2007). Shared trauma: Helping clients cope with national events that affect the therapist. Retrieved March 16, 2009, from http://www.apapractice.org/apo/insider/professional/self0/timelyissues/shared.html
Bauwens, J., & Tosone, C. (2010). Professional posttraumatic growth after a shared traumatic experience: Manhattan clinicians' perspectives on post 9/11 practice. Journal of Loss and Trauma, 15(6), 498–517.
Dekel, R., & Baum, N. (2009). Intervention in a shared traumatic reality: A new challenge for social workers. British Journal of Social Work, 40(6), 1927–1944.
Eidelson, R. J., D'Alessio, G. R., & Eidelson, J. I. (2003). The impact of September 11 on psychologists. Professional Psychology: Research and Practice, 34(2), 144–150.
Fast, D., Black, F. W., Abrahams, J. P., Warner, M. S., & Bellando, B. J. (2008). After the storm: Katrina's impact on psychological practice in New Orleans. Professional Psychology: Research and Practice, 39(1), 1–6.

Saakvitne, K. W. (2002). Shared trauma: The therapist's increased vulnerability. Psychoanalytic Dialogues, 12(3), 443–449.
Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers. Clinical Psychology Review, 23, 449–480.
Seeley, K. M. (2008). Therapy after terror: 9/11, psychotherapists, and mental health. New York, NY: Cambridge University Press.
Tosone, C. (2006). Therapeutic intimacy: A post-9/11 perspective. Smith College Studies in Social Work, 76(4), 89–98.
Tosone, C., & Bialkin, L. (2003). The impact of mass violence and secondary trauma in clinical practice. In L. A.Straussner & N. K.Phillips (Eds.), Understanding mass violence: A social work perspective (pp. 157–167). Boston: Allyn & Bacon.
Tosone, C., Bialkin, L., Campbell, M., Charters, M., Gieri, K., Gross, S., … Stefan, A. (2003). Shared trauma: Group reflections on the September 11th disaster. Psychoanalytic Social Work, 10(1), 57–77.