The Trauma Contagion

by Graham Gill-Emerson

Introduction

Traumatic experiences hold a central place in the therapy room. As therapists, we are acutely aware of the difficulties trauma brings to the everyday lives of our clients and are mindful of the delicate journeys that need to be negotiated in our client's trauma recovery. So too are we aware of the impact trauma can have on ourselves as practitioners, emphasising our use of self-care to stave off the onset of vicarious or secondary traumatisation that may potentially lead to burnout.

Less time however may be given to acknowledging the impact trauma can have on the survivor's broader system of care. This article focuses on the belief that 'if a helping professional can become vicariously traumatised when listening to the story of a client relatively unknown to them, the trauma survivor's significant other is also (and possibly more) likely to experience such issues'. Yet, how often have we included partners in therapy as co-survivors or spoken to survivors about their partners' needing their own individual therapy? Ultimately, can we increase efficiency of therapeutic success by including the partner in the recovery process? And if so, what form would this take?

Background

Descriptions of trauma widely agree that its cause lies in an event that is experienced as being a powerful psychological shock significant enough to overwhelm and through which one can lose their sense of control, connection and meaning.

In a small yet significant proportion of the population, trauma is followed by the onset of Post Traumatic Stress Disorder (PTSD). This psychiatric diagnosis, is largely framed as the residual manifestation of trauma occurring for longer than one month post a traumatic event. Its lifetime prevalence in the adult population of the United States is 8% (DSM IV-TR, 2000), while the prevalence of probable PTSD in the North of Ireland is thought to approximate 10% of the population after a protracted period of political conflict (Muldoon & Downes, 2007). Its characteristic symptoms include the persistent conscious and unconscious avoidance of stimuli which remind the individual of the event, a heightened sense of arousal to triggers, and impairment in social, occupational and other areas of the victim's external world. It can occur where one experiences, witnesses or learns of a serious threat to life, injury or physical integrity to themselves or those around them.

PTSD is recognised in this article for both its origins in and pertinence to trauma and for its recognition of the trauma experience extending beyond that of the primary trauma survivor to a third party

> *learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate* (DSM IV-TR, 2000 p.463).

These third party aspects of the trauma experience are termed 'trauma contagion' and have the potential to occur within trauma cases whether PTSD is present or not.

Trauma Contagion

Trauma can be conceptualised as infectious by both physically witnessing a victim's trauma or by learning about it. Despite this, much of our trauma literature has been compiled on the effects of trauma upon the primary survivor.

> *Emotional contagion refers to the individuals' tendencies to mimic the emotional expressions of others* (Feldman & Kaal, 2007 p.22.)

This emotional contagion can be broken down into the two concepts of 'vicarious trauma' and 'secondary trauma'. Though much has been written over the past number of years on these concepts, there has been a

lack of clarity between the two terms. The similarity between vicarious and secondary trauma is evident in their characteristic of being communicable. They can be differentiated from each other with vicarious trauma concerning itself with alterations in the individual's usual ways of understanding themselves and their world, i.e. perspective; while secondary trauma locates itself within the mimicking of trauma symptoms, i.e. the felt sense.

The term vicarious trauma was introduced by McCann & Pearlman (1990) and can be understood as

> *related both to the graphic and painful material trauma clients often present and to the therapist's [or listeners] unique cognitive schemas or beliefs, expectations, and assumptions about self and others* (McCann & Pearlman, 1990 p .131).

Vicarious trauma research has largely focused on how the professionals that work with trauma survivors or within traumatic environments (such as first responders and therapists) are impacted.

However, stress symptoms can also be communicated to those close to the trauma survivor, who can become 'infected' with similar trauma symptoms (Goff et al, 2006 p.451). These Secondary Traumatic Stress Reactions (Figley, 1983) posit that at a foundational level, being a family member or engaging in a deep caring relationship predisposes us to being emotionally vulnerable to the catastrophes which impact loved ones.

Thus a ripple effect is generated where people connected to the victim also experience a trauma, mimicking the trauma survivor's symptoms.

In this way, the traumatic experience can go on to impact the "psychological, emotional, physical, operational, social and spiritual subtypes of intimacy" (Mills, 2001 p.198) for both the individual and/or the couple involved.

So how can we treat trauma? We often work with individual clients, speaking about the importance of the extra-therapeutic support people. As outlined above, these people too may be affected, reducing their ability to support and increasing their potential to be reactive as a co-survivor. To treat a traumatised client in a loving relationship may be akin to treating someone individually for a contagious disease (e.g. Tuberculosis) in a sanitised environment before sending them home to their infected family. In this scenario, one would imagine that recovery would be slow at best!

What does the research tell us?

Research in the area of trauma emphasises the need for self-care throughout, be it for the client, the therapist or the survivors support network.

The effects on child sexual abuse survivors and their spouses of common treatment modalities were explored by Reid, Wampler and Taylor (1996). Each of the modalities explored excluded partners. The authors point out that the literature provides much evidence around treating the child abuse survivor with limited consideration being given to the partner's role in the dyadic process of recovery. They warn that ignoring current issues in the relationship when treating the survivor of childhood sexual abuse ignores how the abuse issues are replayed within the current relationship.

Current literature and conceptual explanations of PTSD-like symptoms in female partners of war veterans were explored by Nelson & Wright (1996).

The study stated that assisting and supporting female partners through treatment may be essential to the overall aid of both partners in the treatment of PTSD. It expanded on this by stating that

> *Effective treatment should involve family psycho-education, support groups for both partners and veterans, concurrent individual treatment, and couple or family therapy* (Nelson and Wright, 1996 p.462).

In attempting to identify how intimate relationships are affected when there is a history of trauma exposure, Goff et Al (2006) argued that any treatment of solely the trauma survivor may potentially miss the consequences for the couple and larger family in addition to couple interactional patterns which may exacerbate symptoms in the primary survivor. Thus in the provision of clinical treatment, it is critical to identify the fallout of trauma upon the couple's functioning in order to promote healing for both the primary and secondary survivors and to prevent further systemic damage from the trauma. It was the study's contention that adjunctive conjoint sessions with the couple are essential to adequately address dyadic issues and to reinforce the partner's support in the healing process. The authors warn that most therapists will struggle to maintain a balanced focus in this sort of couple therapy, often shifting their emphasis to the survivor and may "fail to acknowledge the partner's experience as a co-victim" (Reid, Wampler and Taylor, 1996 p.451).

Finally, Henry et Al (2011) outlined how interactional patterns within the couple and/or family may be symptomatic of the primary trauma. They argued that there are a variety of mechanisms that affect functioning in relationships where at least one partner is a trauma survivor, and that understanding the effects of trauma within a couple and family system will improve therapists' abilities to facilitate successful interventions.

Trauma Recovery

Returning to a previous state of being prior to a trauma is commonly referred to as recovery. This recovery

can be conceived as the fundamental shift that occurs in our being when we successfully renegotiate trauma. These fundamental changes occur in our nervous systems, feelings and perceptions as one makes the transition from a traumatic to a peaceful state (Levine, 1997).

In the therapy room, trauma recovery is facilitated through three steps (Herman, 2001). The central tasks of these steps are:

1. To establish safety.
2. Remembrance and mourning.
3. Reconnection with ordinary life. (Herman, 2001)

Despite this linear presentation, the journey of recovery is not straightforward but instead oscillates, defying any attempt in applying order to the experience. However, it should be possible to

> *"recognize a gradual shift from unpredictable danger to reliable safety, from disassociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection"* (Herman, 2001 p.155).

Though Herman's (2001) stages of trauma recovery are written for the benefit of therapists working with primary trauma survivors in resolving PTSD, this does not preclude its application in treating secondary survivors.

However, Remer & Ferguson (1998) present a thorough six stage model representing the steps and complexities involved in the healing process of the secondary trauma survivor (see Fig. 1.0).

Pre-Trauma:

This stage acknowledges the primary and secondary survivor's assumptive world views, noting that we are social beings impacted by how we perceive the world through individual, social, personal and cultural contexts. The more alike the two partners' histories, the greater chance their pre-trauma stages will be alike. The influences of this pre-trauma stage may remain hidden within a relationship unless amplified by the occurrence of a significant stressor. When such an incident does occur the effects of this stage will permeate throughout the recovery process.

Trauma Awareness:

The secondary survivor's healing is going to be impacted by how much and how soon they become aware of the trauma. The more aware of the whole trauma, the more able the secondary survivor will be able to spot and manage its repercussions.

Crisis and Disorientation:

Once the trauma is recognised, it can now be addressed. Shock, confusion and denial may follow, with periods of the secondary survivor feeling off balance and confused.

Outward Adjustment:

This marks a brief return to the previous life of the couple pre-trauma. It is based on the partner dichotomous positioning of disowning the impact of the primary survivors traumatic experience, while at the same time endeavouring to be fully supportive.

It will manifest at both the personal and relationship level. At a personal level, defence mechanisms will dominate while established role patterns will present at a relationship level. These two levels will interact significantly and will continue for as long as both the personal and relationship aspects coordinate in the maintenance of this cosmetic façade.

Reorganisation:

The same two aspects occur at this stage. At a personal level, the defence mechanisms that maintain the particular schema involved in adaptation will be addressed and renegoti-

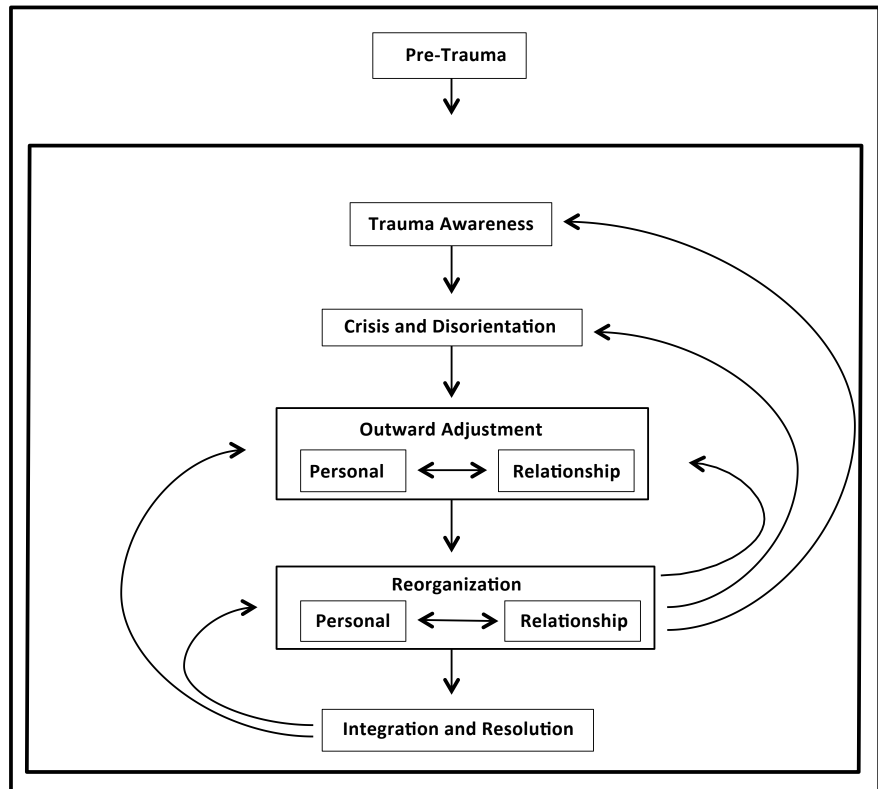

Figure 1.0 Processional Stage Model of the Secondary Survivor Healing Process. Remer & Ferguson (1998, p.145)

ated. At a relationship level new roles will be developed and implemented. Effectiveness at this stage will result from the couple's ability to negotiate and coordinate such changes. The difficulty level involved in these changes will be partly determined by the couple's pre-trauma relationship.

Integration and Resolution:

Integration involves accepting the trauma and making it part of the secondary survivor's personality. Resolution refers to the individual's ability to spot the enduring aspects of the healing process as they progress, perhaps forever.

Earlier in the process, memories and insights often recycle back into crisis and disorientation, while new information at the final stage will likely recycle back to the reorganisation stage where new information is managed and worked through quicker and more effectively.

Though it is not the focus of this article, it is worth noting that some individuals experience a positive outcome as a result of trauma. This trauma thriving or post traumatic growth has the potential to leave people in a better psychological state as a result of their ordeal. Such positive change spans the three broad categories of self-perception, interpersonal relationships and philosophies of life (Tedeschi & Calhoun 1996 p.457).

Conclusion

It would seem that there is a general consensus among helping professionals around the existence of trauma contagion in the form or vicarious and secondary trauma leading to a need for greater self-care when dealing with such cases. It would seem that we as professionals give less thought to how this contagion may be affecting the client's broader system of care, utilising those close to the client in trauma treatment as a support while often failing to identify and treat them as co-survivors. It is hoped that this article has increased therapist awareness on the effects of trauma within client's relationships through the focus on how this trauma may be experienced by the partner and how this may in turn slow the process of recovery for both client and those they relate to. It offers a framework for trauma recovery for the client and their partner as well as charting a brief summary of suggested approaches brought forth by research in this area.

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