EDITORIAL

Purification and the Self-System of the Therapist

Recently, I found myself leading a discussion in our synagogue on the meaning of purification rituals in the Old Testament. The study portion of the morning included a finely detailed description of an obscure purification rite to be performed by individuals who come in contact with the dead. The process of finding meaning in the portion (my assignment) led me to a reflection on the process of growth and transformation in my clients, my trauma colleagues and myself, and the importance of the notion of “purification.”

My rabbi gave me two keys to the portion. The first was to consider that “ritual impurity” may have suggested something beyond “taint” to the ancients. “Impurity” could be interpreted more broadly as something having to do with consciousness and the need to transform it. To illustrate this he told me of a personal experience he had as a rabbinical student. As part of his rabbinic training, he participated in the ritual purification of the body after death—in Jewish religious life, a great “mitzvah” or good deed. After performing this solemn and sacred act he noticed
that he could not easily slip back in with his fellow students who were playing or studying. He now understood the need for some process of “purification.” He did not experience himself as “tainted,” only profoundly changed by the act of tending to the corpse. To re-enter the mainstream of his life he needed something such as a ritualized process.

Seen through this lens, cleansing or purification rituals are responses to altered consciousness, ways of bringing one back to oneself. Most importantly, the ritual of purification signifies that there is a path of renewal and transformation. We can be redeemed, returned to ourselves. Thus understood, rites of “purification” serve survival. Ritualized process bring us back to ourselves after we have been overwhelmed and disordered by experience, such as tending the bodies of the dead might do. In this search for meaning in this ancient, seemingly superstitious ritual, I was struck by the parallels between the Talmudic understanding about states of “impurity” and redemption therefrom, and trauma and its treatment. In the overwhelming aftermath of trauma with its confusion and shattered meaning, treatment has profound effects on patient and trauma therapist alike and carries the hope for a redemptive journey back to the self.

The rabbis of the Old Testament were not the only ones interested in this journey of restoring order and composure to consciousness. Mary Douglas (1966), a contemporary anthropologist addressing issues of taboo and pollution in primitive culture and mainstream religion has studied the role of “dirt” and sacred cleansing in the renewal of spirituality. Douglas sees purification rites as means to focus and control experience, serving the function of restoration for those who participate in them. Purification rituals put right what has been disordered in experience, imposing a “... system on an inherently untidy experience” (p. 5). “Reflection on dirt involves reflection on the relation of order to disorder, being to non-being, form to formlessness, life to death” (p. 7).

SECONDARY TRAUMATIC STRESS/VICARIOUS TRAUMATIZATION

Trauma therapists know about disordered experience; it is their stock in trade. They know about the need to “focus and control.” They participate in the renewal process, the patient’s rite of passage back to themselves. Their participation as helpers engenders intense experiences of their own, as they pass through and are changed by the disordered experiences of their patients, particularly with the most severely traumatized and dissociative patients. Re-enactments within the treatment, thera-
peutic crises, impasses, suicidal threats and actions all generate the most intense countertransference reactions in empathic and engaged therapists. Therapists watch as their patients are caught in the grip of tormenting flashbacks, somatic re-experiencing, and very real physical suffering. Attuned therapists may experience primitive and intense affects themselves, including helplessness, feelings of unworthiness, fear, primitive rage, sadism, sexual arousal, and identification with the perpetrator as well as the victim. They may endure their own physical changes/pain in response to the dissociated experiences of their patients. Davies and Frawley eloquently describe some of those experiences:

We have felt inexplicably nauseous, terrified, bigger, or smaller, have had tingly skin, numbness in an extremity, headaches, dizziness, vaginal pain, or contractions, or have experienced sexual arousal, all of which were disorienting and alien to a normally functioning ego. (p. 151)

It is not difficult to understand how trauma therapists become periodically overwhelmed. Schwartz (1994), among so many others, observes that "by psychotherapeutic necessity, treatment is traumatic for the therapist" (p. 220). Trauma therapy perhaps more than any other therapy requires fully entering into the internal world of the patient, a voyage to the other side and back that will change the therapist as well as the patient. A significant literature already exists on the negative effects on clinicians of treating trauma. The ubiquity of these phenomena is reflected by the number of designations for this professional hazard: "secondary traumatization," "compassion fatigue," "traumatic countertransference," and "vicarious traumatization." Nor is this an exhaustive list. Many of these designations refer to changes in the self-system of the therapist, enduring change in beliefs, worldview, and sense of self. "Vicarious Traumatization" (VT) specifically refers to alterations in therapists’ view of themselves and the world. Pearlman and Saakvitne (1995a) who have studied the deleterious effects on trauma therapists note:

We have come to believe over time that the most malignant aspect of VT is the loss of a sense of meaning for one’s life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one’s experience... best described as spirituality. (p. 160)
Although not yet widely studied, my experience and that of colleagues would indicate there are changes in a positive direction as well. As Douglas (1966) puts it, a trauma therapist needs to restore order to the disordered experience that is part of the therapy, requiring a major shift in the self-system of the therapist as well as the patient. The shift can be enhancing as well as, or in addition to being harmful. To fall back on the Old Testament once again, Jacob, who meets and wrestles with an Angel in Genesis, is transformed by this encounter. He wrestles all night with an Angel of God and prevails. He extracts a blessing from the contending Angel who anoints him with a new name, “Israel.” Jacob emerges transformed, triumphant, but injured as well. The wrestling Angel leaves him with a limp. Trauma therapy will present us with challenges that feel bigger than we are. If we choose to engage these challenges we may be changed, enhanced, as well as injured.

Some empirical support for this observation appeared in a national randomized survey sample of women psychotherapists (Brady, Guy, Poelstra, & Brokaw, 1999). The survey was designed to evaluate the effects on women therapists of doing trauma work. Brady et al. found that alongside evidence of VT there was strong, significant evidence for increased spirituality in therapists who saw more sexual abuse survivors as compared to those who saw fewer. Interestingly the authors used the metaphor of purification in their conclusions:

Perhaps the analogy “purification by fire” is appropriate here. Confronted with clients issues of meaning hope and spiritual understanding female psychotherapists’ own faith may emerge stronger and more resilient. Psychotherapists who see less trauma clients may have less cause to address issues of spirituality and as a result be less apt to grapple with their own spiritual questions. (p. 392)

This would suggest there really are some benefits to being a trauma therapist. The painful confrontations with the dark side of human nature, the intense exposure to suffering and survival therefrom, and acting in the role of healer and companion on the journey of recovery brings the therapist to a place where they must consider existential and spiritual questions. Their work can become an important part of their own journey of growth and development.

Spirituality is but one dimension along which trauma therapists may undergo profound changes in their assumptions about the world and themselves within the world. Self-esteem, empowerment, wisdom, in-
tellectual maturity, hopefulness, a sense of personal growth and healing, and increased motivation toward social and political activism are categories of profound change that are mentioned in the literature (Benatar, 2000; Maroda, 1999; Pearlman & Saakvitne, 1995b).

Dori Laub (1992) reflecting on the experience of treating Holocaust survivors writes

... the holocaust [sic] experience is a very condensed version of most of what life is all about: it contains a great many existential questions, that we manage to avoid in our daily living, often through preoccupation with trivia. (p. 72)

Certainly something similar could be said about work with all trauma. Therapists whose daily fare includes wrestling with existential questions will undergo consciousness change right along with their patients.

**RELATIONAL THEORY**

Parallel with the development and elaboration of trauma theory and the deepening of clinical practice in this area are developments in contemporary psychoanalytic theory that emphasize the two-person nature of all clinical treatment. Analytically informed therapists have moved more toward a relational understanding of clinical process, wherein the subjectivity of the analyst/therapist becomes an important object of study along with that of the patient (Aron, 1999; Bromberg, 1998; Davies, 1998; Hoffman, 1998; Renik, 1999). The analytic reality is a two person, inter-subjective reality and therapy is a co-constructed process. A relational approach to treatment will naturally lead to a focus on re-enactments in the treatment transactions between patient and clinician that unconsciously re-create the drama of key developmental issues in the patient’s history. Trauma therapists are both theoretically and clinically integrating this intersubjective perspective in their work (Davies & Frawley, 1994; Howell, 2002; Schwartz, 1994).

A relational focus on transference/countertransference configurations would or should bring our attention to the therapists’ experience of trauma therapy on dimensions that would include not only negative effects but also something akin to what the client goes through in a positive way. The transformative passage leaves the therapist altered on the other side of an intense and meaningful treatment-not just traumatized,
but deepened and matured with their consciousness and sense of self transmuted in a desirable direction.

Writing on the implications of a relational and intersubjective way of working with transference and countertransference, Maroda (1999) states this most strongly and clearly: “The analyst must be willing to be continually transformed by his or her therapy experience” (p. 5). Indeed, her thesis seems to be that treatment will not be successful unless there is a change in the analyst as well as the patient. In the process of changing themselves, patients desperately need the validation of seeing the impact of their shared experiences on their therapists. Therapists must be affectively engaged at the deepest level for the patient to be reached.

**POSITIVE SELF TRANSFORMATION**

Trauma is by its very nature unsymbolizable—experiences that cannot easily be described through words or managed through verbal expression. As a result trauma-focused therapy inevitably involves working with nonverbal affects and experiences over time that are re-enacted within the treatment. Davies and Frawley (1994) in their discussion of treatment with survivors of childhood sexual abuse summarize these phenomena:

Such reenactments involve the unconscious recreation in the treatment setting of dissociatively unavailable aspects of self and object representation-aspects that cannot be verbally described but can via projective-introjective mechanisms, particularly projective-identification volley back and forth between patient and therapist in startling reconstructions of early trauma . . . Within this model, re-enactments are crucial. (p. 3)

It is this reality that sets the stage for growth and change in the therapist as well as the patient.

I propose the term “positive self transformation” (PST) as a construct—a correlate to Vicarious Traumatization—that connotes the transmuting of the therapist’s self-system in the direction of increased maturity and self development. PST is a possible, not inevitable product of being a therapist engaged in the long term therapy of trauma survivors, and does not exclude secondary traumatic stress effects.
Only a few in the trauma and psychoanalytic literature have commented on the growth and self development of the analyst/therapist fostered by treating patients, the generative and maturing effects of being a therapist. DePaola (1990), a Brazilian Kleinian analyst, wrote in regard to treating “regressed patients” who rely heavily on projective identification, that the analyst is in a “constant reparative process of (their own) internal object relations” (p. 328). She sees the analyst as projecting his own internal objects into the patient, identifying with those objects and then repairing them. The analyst “treats those parts in his internal world (engaged by the patient’s projections) since the analytic function is a constant reparative process in the psychoanalyst’s internal object relations” (p. 328).

Ruderman (2002) who has studied gender-related themes as they emerge with female therapists treating women patients and their counter-transference, notes the opportunities for growth that patients provide their therapist. Citing case examples from her own experience, Ruderman observes the opportunity for mourning losses, and wrestling with impasses in the therapist’s own development that working intensively with patients provides.

**PARENTING AND BEING A THERAPIST AS DEVELOPMENTAL OPPORTUNITIES**

One model for thinking about the process of PST is provided by the study of the developmental processes of parenthood. Theorists as diverse as Selma Fraiberg, Edna Benedek and Miriam Elson have looked at the developmental challenges parents undergo while fostering the growth of their children and the consequent potential for change within the parents. In a seminal paper “Ghosts in the Nursery” (Fraiberg, Adelson, & Shapiro, 1975), Fraiberg focuses on the unconscious resurgence of parents’ own past trauma in the context of performing early parenting tasks. The “ghosts” of the title are the “visitors of the unremembered past” (p. 22) of parents, which can impair and impede successful attachment and attunement to the infant. Access to the parent’s own pain is required for successful resolution of these intrusions.

Benedek (1970), focusing more on the positive potential for parental growth, notes that unconscious identification with one’s own child at developmental stages triggers parallel historical conflicts within the adult, providing the potential for parents to resolve their own reactivated psychic conflicts.
Elson (1984), a self psychologist, speaks more of the potential for evolving narcissism within parents’ self-system—an opportunity to “fill in the gaps” in areas of deficits within the parent.

. . . the responsive mirroring, echoing, confirming, guiding function of parents as selfobject is uniquely transmuted by the child into psychic structure, but it is a two-way process in which parental structure also undergoes transformation. (p. 298)

At each point of development, new demands are made upon parents to empathically meet the needs of their children. Even parents of adult children are required to understand, support and be empathic with their adult offspring, which may require reworking and maturation of parental narcissism. Additionally Elson notes that the generative roles of helping others, writing, and teaching also hold this possibility. To this list I would add being a therapist, particularly a trauma therapist.

Attachment theorists speak of the “internal working model of parents” that get triggered by the task of caring for their infants and young children—internal representations that may impede the building of secure attachment bonds. This is the mechanism for the transgenerational transmission of trauma. Fonagy et al. (1995) note, however, that not all traumatized parents repeat traumatization, passing the “trauma baton” to their offspring. Retraumatization is not inevitable. Becoming a parent “may [also] trigger an adaptive reorganization [emphasis mine] of the inner world of the parent” (p. 242).

Whatever theoretical models are applied it seems evident from my experience that being a therapist—like being a parent—provides intrapsychic opportunities for the therapist. This need be neither an exploitative or conscious process. The patient’s well being is no more sacrificed for the developmental enhancement of the clinician, than that children suffer from the increased maturation of their parents. The therapist’s personal growth can be a natural outcome of the collaboration. Much as parents are called upon to “grow themselves” to be the kind of parent their child needs at a particular moment in time, so are therapists required to “grow themselves” to effectively meet the exigencies of clinical work.

Trauma therapists may have more opportunities for PST than others by virtue of the fact that trauma patients rely more heavily and sometimes exclusively on dissociation and projective identification to both cope and communicate. Re-enactments are an expectable part of clini-
cal work with survivors of childhood abuse (Davies & Frawley, 1994; Maroda, 1999; Pearlman & Saakvitne, 1995b; Schwartz, 1994).

Alan Schore (2003), in describing the comprehensive integration of psycho neurobiology and the processes of enactment and projective identification in psychodynamic treatment, notes both the bi-directional nature of the unconscious influencing that goes on between patient and therapist and the neurological basis for the process. The right brain of the patient, the emotional, psycho-somatosensory seat of experience communicates with the analyst’s (or read trauma therapist’s) right brain. Internal affective states are communicated bi-directionally in this way.

An integration of current developmental studies of infant-mother emotional communications, psychophysiological data on affective processing, and neurobiological research on the essential role of the right brain in emotional communications can offer us a deeper understanding of the mechanism of affective communications within projective identification. These right brain to right brain communications embedded within the attachment bond represent what Bion calls links between mother and infant. (p. 61)

Conceptual experiences like reverie, empathy, attunement, and enactment all refer to this process as they apply within treatment. Patients’ and therapists’ right brains are communicating affectively and are designed to do so.

The therapist or analyst is called upon to tolerate a high level of affective arousal in this “right brain to right brain process,” the “mix-up,” as Schore refers to it. It is the clinician’s ability to receive and tolerate these indirect, visceral, dissociated communications that facilitate eventual resolution of conflict and greater integration for the patient. The process is thoroughly mutual and intersubjective. The clinician is called upon to tolerate a very high level of stress, ambiguity, and instability during key crises in the treatment. Clinicians’ own defensive patterns and internal conflicts are inevitably engaged in this process, stimulating clinicians’ own interior noise. This “mix up” calls for “purification.”

Premature interpretations, negative counter-transference reactions and acting out on the part of the clinician may well be understood as the clinician’s attempt to restore order in the midst of confusion and stress. Unfortunately they also serve to push the patient back onto the mechanisms of dissociation and defensive projective identification. A certain amount of containment, of tolerating the mess, of recognizing and regu-
lating negative affect must precede interpretation and symbolization. Affect needs to be held and metabolized. It is this process that we generally understand to promote growth in the patient. Additionally, it also holds the potential for promoting growth in the clinician.

Schore (2003) and others before him emphasize that the analyst’s ability to both be affected by the patient’s projections and tolerate the negative affect without grossly acting out will be subtly communicated to the patient that he/she is in a safe interpersonal environment. Thus, it is the containment, rather than the interpretation that is central to the process of repair. Additionally, it is this very stress on the clinician that sets the stage for both negative outcomes in treatment or alternatively the positive self transformation of the therapist.

CASE EXAMPLE

In work with Amy [previously discussed at length in Benatar (2003)], a pivotal crisis in a long term treatment involved living through and enduring the possessive love, grief and aggression of a young woman with dissociative identity disorder (DID). The enactment in this case occurred when one of Amy’s alter personalities secretly contacted town officials and had me evicted from a home office. I learned later, much later, that she fantasized that I would see most of my patients in a new office located in a less cozy office building, but would continue to see her in my home office. With some difficulty and after much turmoil in the treatment, I declined to do this.

It took almost two years for her (the alter personality’s) actions to come to light. During that time Amy went on a rampage aimed at me, and, more devastatingly, at herself. Self injury, reckless behavior, and suicidality dominated the treatment. Any attempts I made to understand, interpret, coax, cajole, make contracts, resolve, or innovate failed miserably. Donald, the alter personality that both implemented the plan to exile me from my home office and kept it secret from the host personality, constantly placed me in double binds wherein my every move was wrong. From Donald’s perspective, I didn’t care enough for him/her/ them. It wasn’t my fault; it was his mistake that he thought they were special. Clearly they weren’t and that was the way it was.

Actually “they” were special to me. This was my first diagnosed DID patient. I did feel very close to her and had made many extensions in my
practice as part of her treatment. Additionally treating Amy had brought out many of my own best parts. I had felt strong, ingenious, and creative in my care of her over the years. I had rediscovered a spirituality within my self, long buried, and reignited by exposure to her strong spirit and her belief that she had been helped to survive by a guardian angel. The buoyancy in some of her younger alter personalities and their enduring ability to attach, gave me hope both for her and for myself. Whatever secondary traumatic effects I experienced were well balanced by the gains.

Despite her “specialness” it clearly was not going to work for me to see Amy in my home office. For both logistical and only dimly perceived clinical reasons, I chose not to make this concession to her specialness—to see her in the home office. As a result, Donald’s rage and despair alternated in making sessions difficult or impossible. All that was positive turned to dust. I was no longer in control and certainly not creative. I had to reconcile myself to failure. I just could not figure my way out. Supervision with colleagues, several consultations with more experienced clinicians, reading and rereading the literature all came to naught. I threw in the towel. I let Amy leave treatment although I knew she was in dreadful shape and digging herself further into the ground every day. In retrospect I believe it was my unacknowledged rage with her for her unremitting attacks on me that allowed me to let go of her at the height of her self-destructiveness. My anger matched her own. She was “ruining” the treatment over this seemingly trivial issue, the change of office. All that I had given to her came to naught. In retrospect, I came to see that she was as angry with herself for her aggression toward me as she was with me for my failure to make special arrangements. At the time there seemed no choice but to let her go. I think the fury that she inspired in me, was a player in this drama.

It was only a matter of weeks until she returned to treatment and with enormous shame disclosed her actions against me. This ushered in a time of astonishing growth and integration. Many if not all of Amy’s alter personalities began to unify and did not re-dissociate or re-emerge in the many years after these events.

As a young teen, Amy had reported being abused by her father to child welfare officials, an action that concluded in her being placed in a foster family. She had appealed to her mother to prevent the placement by moving them both to safety away from the father. Mother had been unable to make this move and Amy went into placement. Amy had reported me to the “authorities,” just as she had her parents. In the therapy, she re-enacted the agony of not being chosen by her mother over her sa-
distically abusive father, and thus being forced to leave home as a young teen. Her broken heart as well as her rage over these events as she re-en acted them came perilously close to destroying the treatment.

While in some sense I replicated the mother’s actions by refusing to continue treatment in the home office and then later when I “allowed” her to leave treatment briefly, I believe the growth and integration we saw shortly after the disclosure of this incident came as a result of my holding onto her despite my knowledge of her aggression against me. My acceptance of her at that point redeemed me as her therapist/parent. She expected me to retali ate when I learned of her actions against me, to let her go into exile, as her mother had. She gave me a second chance. This time I did not let her go. She began to come together, to integrate and grow.

To be able to forgive Amy for what could have been a ruinous action on her part, required qualities I did not know I had and quite likely didn’t have. In retrospect it seems that my attachment to her, my relief that a prolonged and bewildering crisis was resolving, trumped whatever anger I might have had over the disruption to my practice. I admired the courage in Amy’s confession and the transformation in her that it seemed to usher in.

Looking back on this treatment, which continued for many years after the events described above, I see two levels of PST as it applies to my own development. In the first two years or so of treating Amy I had to fashion a renewed identity as a therapist. I literally had to grow myself to treat her. I needed to learn quickly how to understand and treat a complex dissociative disorder. I needed to be resourceful, inventive, and resilient as never before in my clinical work. Strangely this increased effort freed energy within me, rather than depleting it. In many ways I came into my own as a therapist in those first couple of years.

The second level of PST is more difficult to conceptualize and articulate at this point. Through the re-enactment described above I experienced the projected rage, frustration, and despair of my patient, as well as the deep attachment that we shared. I was called upon to manage my own anger. I believe Amy’s dissociated perpetrator parts met my own dissociated perpetrator parts, we wrestled, we endured and in the end we both survived the encounter. It was that survival that was healing to us both. The attachment triumphed over the despair. Love trumped rage. I suspect that this is what was finally redemptive. For Amy and I there was resolution, our anger with each other, even our acting out against each other did not win the day. She found the courage to return to treatment and confess, and this moved me so profoundly that there was no
question I would forgive her and even myself. Amy had not experienced this with her family, her mother’s attachment to her was not strong enough to overcome her own fears and so Amy lost her. There are enough dim echoes of this in my own family history, so that our re-union–Amy’s and mine, her decision to return and come clean, and tac-itly forgive me for my limitations was balm to my own soul.

Laub and Auerhahn (1993) describe the power of the Holocaust as a metaphor for individuals to conceptualize their developmental conflict, and as a vehicle for organizing intrapsychic life. In a similar way, I have come to realize that Amy’s story, her resilience, and her adaptation provided me with a powerful metaphor to understand my own history and my own stubbornly knotted internal impasses.

**CONCLUSION**

Re-enactments in the context of trauma transferences engage the therapist in very specific, usually intense ways. It is my argument that these kinds of engagements with patients that activate primitive their early childhood attachment needs, will or can evoke the attachment system of the therapist, and can bring about positive change in the therapist’s self-system. Much as the attachment system of parents is engaged by the insistent needs of infants and children, the therapists’ attachment system is engaged (at a diminished intensity) by the powerful nonverbal needs of the patient. As with parents who need to meet the needs of their children, therapists often have to rework their own injuries and their own stuck places.

Much attention has been given to the negative effects of intense long term work with trauma survivors. However, recognition of secondary traumatization effects does not exclude the possibility of what I am calling positive self transformation—the more salubrious effects of being a trauma therapist. Therapists who are able to successfully rework and adapt within themselves will be able to transform re-enactments and not merely repeat with the patient unconscious failures. I think Winnicott (1954) says it best:

> I cannot help being different from what I was before the (process) started . . . The treatment . . . called on everything that I possess as a human being and as a psychoanalyst . . . I have had to make personal growth (over the course of this period) which was painful and which I would gladly have avoided. Hopefully, the pain I have
felt translated into being a better therapist. At least I believe this to be the case. (p. 280)

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NOTES

1. Thanks to Elizabeth Howell for this biblical reference.
2. Thanks to Jennifer Almouli of NIP Trauma Treatment Program for this insight.

REFERENCES


