

**Common Shock:
Witnessing Violence in Clients' Lives¹**

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¹ This article has been adapted from K. Weingarten. 2003. *Common Shock—Witnessing Violence Every Day: How We Are Harmed, How We Can Heal*. New York: Dutton

Whether we like it or not, all of us are witnesses every day to violence and violation. Sometimes the violence we observe occurs between people we know. At other times, we may just happen to be somewhere – like in a neighborhood park – and see a gratuitous example of violence, for instance a mother swatting her toddler hard on the buttocks. Unexpected scenes may accost us when we are following our usual routines, like turning on the television moments before our favorite show, but on this occasion the horrific dramatic finale of the previous program assaults us. Or, a once in a lifetime occurrence happens, that creates a disturbance that ripples throughout our lives. For some, the Challenger's downward arc into the cobalt blue waters will forever remain etched in their minds. For others, September 11, 2001, 911, will be a marker event.

Exposure to violence and violation is ubiquitous in our daily lives. These events, on a continuum from the ordinary to the extraordinary, produce a response I call common shock. It is *common*, because it happens all the time, to everyone in any community. It is a *shock*, because regardless of our response – spaciness, distress, bravado – it affects our mind, body and spirit. The witnessing of everyday violence and violation jolts us into common shock.

None of us escapes this kind of every day witnessing. For helping professionals, there is yet another layer. For in addition to the routine exposure to violence and violation that confronts us all, we choose to expose ourselves to our clients' stories of violence and violation. We have elected to witness the profound suffering endured by those who are mentally ill, those who are addicted, those who are traumatized and those who are just plain miserable. We have chosen to listen to others' stories of horror and pain, grief and despair, in the hope that in doing so, our caring and compassion can help

ease their suffering. We count on the salutary effects of showing ourselves to be reliable listeners, that is, people who can bear to hear what others fear is unspeakable. However, our choice to witness is not without biological, psychological, and interpersonal consequences for us.

Biological Consequences

The biological effects of common shock fall into a range of categories that researchers distinguish from one another, although there is not necessarily agreement about how to do this: shock, a stress response,¹ a trauma response,² an acute stress disorder,³ and acute or chronic posttraumatic stress disorder³. All have stress in common.

Stress is an alarm reaction to a stimulus the person appraises as emotionally charged or threatening. This state can range from exhilaration to mild or severe discomfort. It has also been called the fight-or-flight reaction; it produces hyperarousal, which is a normal and necessary response to threat.

The fight-or-flight reaction prepares the body for defensive action through a cascade of sympathetic nervous system firings and the release of stress hormones, the most well known of which is epinephrine, or adrenaline. Our physical reactions match the potential demands on us. Our pupils dilate so that we can sense what is going on around us, and the hairs on our skin stand up so that we can sense vibration. The heart's output increases so that more blood is pumped to the extremities, readying our arms and legs to run if necessary. We increase our respirations as well, providing more oxygen for our tissues. At the same time, blood is diverted from the digestive system, producing the

sensation of butterflies in the stomach. Normally, once the perceived danger is past, the body will halt the alarm reaction and restore the body to homeostasis, or a state of rest.⁴

When we are deeply distressed by witnessing violence and violation, for instance when a client has told us a story that we just can't shake, we may find it difficult to halt the stress response, or we may only be intermittently effective at doing so. We may be surprised at what will trigger it off: an item in the newspaper, an image we see out of the corner of our eye, a character in a novel we are reading. We just can't calm our sympathetic nervous system.

The body's "trauma center"⁵ is a structure in the brainstem called the locus coeruleus (LC). It has abundant connections throughout the brain to activate and alert a person, even interrupting an individual if necessary, to ensure that attention is paid to high-priority stimuli. When a person is repeatedly exposed to threat or is exposed to an extreme threat, the LC actually changes; it becomes hyper-responsive to stress signals. This produces the felt experience of hyper-vigilance for the individual. In effect this structure itself becomes traumatized.⁶

Finally, the limbic system plays a key role in the body's response to trauma. Two structures of the limbic system are important to understand since they can help us account for prominent psychological symptoms of trauma. The amygdala, named for its almond shape, assigns emotional significance to incoming signals. van der Kolk, B. A. 1993. Biological considerations about emotions, trauma, memory, and the brain. In S. L. Ablon (Ed.), *Human feelings : explorations in affect development and meaning* (pp. 221 - 240). Hillsdale, NJ: Analytic Press. The other structure, the hippocampus, evaluates, categorizes and stores this information. Coordination between both structures is

necessary for optimal functioning; the one reacts to information and the other makes sense of it. Under conditions of extreme stress, a highly aroused amygdala interferes with and may shut down the hippocampus, resulting in a number of symptoms that are associated with long-term effects of trauma.

As the emotion center of the brain, the amygdala is associated with the experience and expression of fear. Under extreme stress, the amygdala can forge connections between elements in the threatening situation and a fear response without the person having any conscious awareness that this is happening. Thus, people may be left with a fear response to triggers in the environment that make no sense to them.

These are just a few of the complex changes that occur in the brain as a result of exposure to extreme stress. The more the brain has to deal with, the more it will adapt and change. Eventually, these adaptations can become maladaptive.⁵ Thus, people who have been repeatedly exposed to the most troubling kinds of interactions and events, and who have done their best to meet the challenges, may find that they respond with such heightened reactivity that they are overwhelmed a great deal of the time. This is called sensitization. Indeed, their brains are so sensitive, that small matters that might not bother others present big hurdles for them. Children, youth and adults who are exposed to domestic and community violence are a particularly vulnerable group to develop sensitization.

These are the kinds of clients we deal with routinely and they have an effect on us. Psychological responses to witnessing our clients vary widely, but they are reliably affected both by what we witness and also the position from which we witness.

Many people have thought about the former, but few have considered the latter, and yet this dimension has a significant impact on our work. It turns out that we are much better able to withstand witnessing violence and violation, and descriptions of them, if we are confident we can be effective in relation to what we have seen or heard. However, all too often, given the clients' dilemmas and the current context of health care service delivery, professionals feel stymied in their attempts to help and stymied by a health care delivery system that has increasingly limited resources to disperse.

Professionals' Experiences of the Four Witness Positions

In the performance of their duties, counselors may have any of four types of witnessing experiences that we all have the potential for having daily (See Figure One). These witnessing experiences directly impact the counselor and the client, but because of the central role counselors play in clients' lives, the effects can also ripple outward. If counselors are not able to manage their witnessing experiences effectively, harmful consequences may extend to colleagues and the community at large.

A professional who witnesses violence or violation in the course of his work and feels aware and empowered in relation to it is likely to be someone who is practicing effectively and competently (Position 1). This position is positive for all concerned. By contrast, a professional who witnesses violence and violation, is clueless about its significance or implications but nonetheless responds as if he knows what he is doing will be misguided, ineffective at best and guilty of malpractice at worst (Position 2). The negative impact of witnessing from this position may be far-reaching. A professional who is unaware of and thus passive in relation to the urgent need of a client has

abandoned that client. This abandonment may also be a form of malpractice (Position 3). This position too may have long-lasting negative effects. Finally, a professional who is keenly aware of the client's situation but feels helpless to do anything about it, will be of little or no use to his client and highly stressed by his work (Position 4).

In researching common shock, and in talking with hundreds of health care professionals in different parts of the world, the witness position that was described with the most distress was witness position 4. People told heart-wrenching anecdotes in which they were haunted by experiences in which they were painfully aware of what needed to be done, but felt helpless or lacking in resources or expertise to provide it. Counselors who feel ineffective and helpless are at risk of developing their own form of common shock, well characterized by the term "empathic stress reactions."⁸

Psychological and Interpersonal Consequences: Empathic Stress Reactions

There are three kinds of empathic stress reactions that may have significant consequences personally and for one's job and clients: burnout, secondary traumatic stress reactions and vicarious traumatization.

Burnout: Many of us have seen a respected colleague apparently lose empathy for her clients and begin to speak in disparaging terms about them. She may be suffering burnout.⁹ Persons with burnout feel emotionally drained by the work that they do. In most instances, burnout occurs in a healthy person who has had no psychological problems beforehand and who has been drawn to her line of work out of the desire to help others. On the job, stresses gradually mount so that the person feels less and less able to accomplish the goals for which she entered the profession. Often there are

institutional or structural barriers that interfere with the person's ability to work effectively. When this occurs, over time, job satisfaction deteriorates and the person begins to develop physical, emotional, behavioral, work-related, and interpersonal symptoms.¹⁰

Secondary traumatic stress refers to the effects on the helper of being exposed to another person's trauma.¹¹ Whereas burnout usually emerges gradually, secondary traumatic stress can appear suddenly, in response to learning about the primary exposure to a traumatic event of a significant person or a person whom one wishes to help. Secondary traumatic stress is usually accompanied by intense feelings of horror, helplessness and fear. Crucially, the symptoms that accompany secondary traumatic stress may be profoundly disturbing to a professional who subscribes to the belief that his training renders him invulnerable to distress. Although he may know exactly what is occurring to him, he may be unable to respond effectively out of shame and disbelief that "this" is happening to him.

There are several areas of symptoms that are frequently, but not always, associated with secondary traumatic stress responses in helpers who are indirectly exposed to trauma. First, there are psychological symptoms. Chief among them are distressing emotions, such as sadness, rage, fear, or horror. Some helpers experience intrusive imagery of the traumatized person's experience. For instance, a helper may have a nightmare that has elements of a client's experience in it. On the other hand, some helpers are plagued by emotional numbing. They suddenly feel hollow, empty, dull, unable to feel anything about anything or anyone. They close up shop, as it were, not just

on the job, but in all parts of their lives. In addition, they may find that they shy away or avoid any reminders of their clients' experience.

Then there are physical symptoms. The helper may notice a rapid heart beat, sweating, a sense of alertness and vigilance, difficulty concentrating, and insomnia. These higher than usual signs of physiological arousal may be signs that the helper is reacting to the client's trauma. Or, the helper may notice a range of somatic disturbances, especially headaches and gastrointestinal difficulties.

The person may experience behavioral change as well. The helper may have trouble adhering to his usual schedule of activities, find himself overusing alcohol or abusing drugs, or forgo his usual routines of self-care, such as exercise or listening to music. He may throw himself into work, but find that his performance is less effective.

Finally, there are interpersonal changes. The helper may become irritable with people in his personal life, lash out or withdraw. Often the helper must keep his client's confidence and therefore he doesn't feel at liberty to disclose the situation that has been so disturbing to him. Significant people in the helper's life, partners or children, may feel shut out at the same time that they feel adversely affected by the "spillover" from the empathic stress reaction of their loved one.¹²

Perhaps most difficult in terms of the helper's ability to relate to loved ones and friends is that secondary traumatic stress provokes alterations in one's basic sense of meaning and purpose. Trauma disrupts trust. Helpers dealing with secondary traumatic stress, or reeling from it, are engaged with profound questioning of values and purpose that may be disruptive to ongoing relationships, especially if the helper feels unable to share the process he is going through.

Vicarious traumatization: Vicarious traumatization refers to the cumulative effect over time on people working with survivors of trauma. Helpers who deal with trauma survivors are exposed to the details of their abuse. These stories invariably consist of betrayals, failures of protection by people who should have and might have behaved differently, and violations of the victims' basic needs for safety, nurturance, trust, control, and esteem. McCann, I. L., & L. A. Pearlman. 1990. Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1); Pearlman, L. A., and Saakvitne, K. W. 1995. Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue : coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel; and Pearlman, L. A., & K. W. Saakvitne. 1995. *Trauma and the therapist : countertransference and vicarious traumatization in psychotherapy with incest survivors* (1st ed.). New York: Norton.

Exposure to these stories confronts therapists with the reality of human cruelty and the potential for harm befalling us or anyone we love. Additionally, therapists are confronted with the extraordinary challenges that trauma survivors face in repairing relationships, mending the capacity to trust, developing appropriate ways of caring for the self and others, and establishing meaning and hope in the aftermath of confusion and despair.

Empathic attunement to clients, while essential to doing the work, is the specific channel through which vicarious traumatization occurs. For it is precisely in the "taking in" of the client's experience that the therapist risks having her worldview fundamentally and permanently altered.

While secondary traumatic stress and vicarious traumatization share some features, vicarious traumatization develops over a longer period of time and represents permanent changes in the therapist's sense of herself and the world. People can suffer from features of any of these three empathic stress reactions or combinations of all three. These responses are normal, common, expectable and still, often not recognized. Or they are recognized, but the person feels considerable shame about them. Sadly, these are occupational hazards that many people view as personal failings.

Reducing Harm

Professional education needs to prepare counselors to handle the occupational hazard of witnessing violence and violation in our clients' lives with the same degree of competence as any other aspect of our job. Compassion and care are not sufficient to protect professionals from the risk of empathic stress reactions. Professionals must feel effective at providing the services clients need. This requires institutional and governmental commitments.

A great deal is known about how to manage common shock reactions. Figley, C. R. 1995. *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Philadelphia, PA, US: Brunner/Mazel, Inc; Pearlman, L. A., & K. W. Saakvitne. 1995. *Trauma and the therapist : countertransference and vicarious traumatization in psychotherapy with incest survivors* (1st ed.). New York: Norton; Stamm, B. H. 1995. *Secondary traumatic stress : self-care issues for clinicians, researchers, and educators*. Lutherville, Md.: Sidran Press; and Wilson, J. P., & J. D. Lindy. 1994. *Countertransference in the treatment of PTSD*. New York: Guilford Press.

Professionals who have support from their colleagues and their institutions perform better, with more confidence and enthusiasm, and stay longer in their professions. Yet, very few institutions devote the time and resources of their organizations to care for their employees, either preventively or after a problem has occurred, with the sophistication that current knowledge allows. Instead, concern is with productivity, as if empathic stress reactions will not eventually have a significant negative impact on productivity.

The mandate for change must come from an informed public. There is an old-time Maine story that I tell frequently in my practice. In it, a farmer is telling his neighbor about an experiment with feeding his chickens he has done to try to save money. He tells him how successful he has been, until, “just when I got ‘em on pure sawdust, they up and died!” As a society, we are cutting the feed of workers whom we need to perform with excellence and compassion perilously thin; there is too much sawdust. Failing to address directly, specifically, fully and compassionately the inevitable toll that working with others exacts is short-sighted and harmful. It is a way that society harms those whom we don’t want to harm us.

In providing resources and support for professionals to feel effective in their work, altruism and self-interest extensively overlap. For those who do not have support to manage common shock can easily pass theirs to others. Acknowledging counselors’ needs promotes effectiveness. As a society we must insist on no less; the price of doing otherwise is one we do not want to pay.

Word Count 2882

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Dr. Kaethe Weingarten, director of The Witnessing Project (www.witnessingproject.org), is an Associate Clinical Professor of Psychology in the Department of Psychiatry at Harvard Medical School and on the faculty of the Family Institute of Cambridge. Her latest book, *Common Shock – Witnessing Violence Every Day: How We Are Harmed, How We Can Heal* (Dutton, 2003), provides a framework for understanding the effects of everyday witnessing of violence and violation and proposes ways of responding that can transform violence at personal, interpersonal and societal levels.

Figure One

