

In the Belly of the Beast: Traumatic Countertransference

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ABSTRACT

The authors discuss their work together in a consultation process. One author led many groups that were created to facilitate recovery for persons directly impacted by the terrorist attacks on September 11, 2001; the other acted as consultant to the therapist/leader. The leader was a resident of New York City at the time of the attacks; the consultant lived in a distant Midwestern city and the two had never met prior to the work. They describe their experience of working together and the role of this collaboration in the lives of the leader and the groups. Well aware that little exists in the literature about groups led by leaders having experienced the same trauma as group members, the authors pay special attention to the countertransference that each underwent and raise questions about the effects of that on the group process.

“There was a 20-minute window that people had after the first plane hit the second tower of the World Trade Center. People could escape with their lives or be pulverized by the collapsing building or vaporized by the 2,000-degree burning jet fuel.

Trauma work takes a toll on us. People identify us, the therapists, with the trauma. In the community, people associate us with the aspect of the trauma they find indigestible; too many stories of the sound of bodies screaming to earth only to splatter on the ground. Everyone treated was disoriented. Some were detached, others distraught, all deeply affected by the magnitude of the trauma. Previous traumas surfaced like the swelling after a mosquito bite. They

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were just beneath the surface and rose in response to the insult of the current trauma. I began to be irritated with colleagues across the country as they intellectualized the trauma and gave theory for support and understanding.

I resented their theories. I resented my good friends and colleagues who were not in touch with the magnitude of the pain we were all in. Twenty minutes transformed the world.”

—Richard Beck, 9/13/01

Thus began the terrorist attacks on the World Trade Center and the Pentagon, September 11, 2001, an acute mass trauma of the largest proportions in the history of the United States within its borders. Very shortly thereafter, the two authors formed a working partnership: one leading many groups of persons surviving at very close range, the other serving as his consultant from afar. This article is a phenomenological account of their experiences, focusing especially on their use and management of the countertransference arising in the work. The first author, based in New York City, wrote the following on Sept. 13, 2001 to a group therapy listserv of colleagues around the world, describing his inner experience:

There are no words to describe the experience here in NYC. The numbness and shock shift, the terror and fear on peoples' faces, on my face as I wandered through a grocery store aisle unable to make a decision, are pervasive . . . words drift off like clouds into the horizon . . . this is such a difficult time . . . we are doing grief work with our patients . . . while we ourselves are traumatized as well . . . the sense of security—shattered . . . trust—diminished, hypervigilance prevailing, appreciation of a beautiful sunset increased tremendously; the pain and suffering of so many weigh heavily on us.

Little is written about countertransference¹ when treating survivors of mass trauma. Only recently have discussions of

1. The authors define countertransference as the totality of the group therapist's feelings and attitudes, conscious and unconscious, for the group and for the individuals in the group, including those derived from an earlier situation in the group therapist's life that may be displaced onto the current situation.

countertransference when treating trauma of any kind in individual and group settings appeared in the literature. Ganzarain & and Buchele (1987) conceptualized countertransference as the therapist's assuming of one side of various reciprocal roles via projective identification, (i.e., parent and child, seducer and seduced, abuser and victim). Davies & Frawley (1994) have described several transference/countertransference paradigms: the uninvolved, non-abusing parent and the neglected child; the sadistic abuser and the helpless, impotently enraged victim; the idealized, omnipotent rescuer and the entitled child who demands rescue. Phillips (2003) discusses the countertransference, emphasizing the vicarious traumatization components, following a catastrophe or disaster. When the group therapist also experiences the mass trauma, the countertransference is complicated, however, beyond the scope of these previous discussions.

The first author will illustrate examples of his traumatic countertransference based upon his experiences leading groups composed of survivors, witnesses, family members, and first responders, (i.e., police, firemen, emergency medical service workers, employees of organizations who worked in the World Trade Center towers), as well as “ordinary New Yorkers.” These groups took place in hospital settings and office buildings, as well as the author's private practice office.

INITIAL REACTIONS OF THE GROUP LEADER TO THE TRAUMA

The attack occurred at 8:46 on the morning of September 11th. My first patient called and canceled that morning. With no radios or TV in the office, had I not gone outside for a cup of coffee, I would have had no idea about the attack. I listened on a radio with an Egyptian storeowner throughout the morning.

At first, we all thought a small plane had misguidedly struck the building. When the second plane struck there was panic all around. When another plane struck the Pentagon, chaos in the streets followed. Until the point when a colleague asked if nuclear weapons might be involved, I was able to remain somewhat composed. Massive anxiety ensued; I raced to the garage where I had parked my car

and drove six hours out of Manhattan. Later, taking the train back into the city was like riding a car filled with nitroglycerin. Every second we feared an explosion or an attack. The following night cats and dogs filled the train car. The conductor asked me where my pet was. I was ashamed that my two cats remained behind in Manhattan as I made this commute one last time.

On September 17th, a company whose employees observed all the horrors of the attack called us to begin work with their staff. Getting there meant taking a subway ride past the World Trade Center site. It was terrifying to be on the train. Would there be poisonous gas released on the train as in Japan? Would the subways be bombed also? The smell of burnt flesh and burnt metal was intense as we proceeded underground.

We were in a war zone. Tanks were everywhere. Police and soldiers were everywhere. We needed to show identification every block we walked until we arrived at our destination. We were as traumatized as the people we were treating . . . We felt the helplessness and impotence that the members felt, the same angst.

INITIAL REACTIONS OF THE CONSULTANT TO THE TRAUMA

I was with one of my patients during a psychoanalytic session. My immediate response was one of disbelief, but then fearful concern for the safety of my husband as I realized he was in Washington, D.C. on business. I could not reach him. After two long hours, he called, saying he was stranded, but okay. We strategized about how to get him home since all flights were canceled and rental cars were unavailable. It felt good to concoct a plan that did get him home, albeit after many hours of driving; my sense of helplessness was temporarily lessened, but from the moment the tragedy occurred, there was a sense of helplessness that quickly grew to painful proportions. What about my friends and colleagues in New York City? Were they alright? How could I help them? What could I do?

I knew what was happening to me. . . The foundation for my countertransference was painful and intense from the beginning.

Freud originally believed countertransference to be an obstacle in the therapist's attempt to help patients recover. Subsequently, we have learned that while identifying, experiencing, and managing the countertransference can be a most difficult part of the work, it can also be an exceedingly valuable diagnostic tool and means of

communicating the patient's experience as well as the cornerstone for the therapist's capacity to be empathic. Identification of the countertransference is a prerequisite to all these useful functions and diagnosing it requires taking distance. When the therapist has experienced the same trauma as group members, taking distance is laden with complications. Davies & Frawley (1994) comment on this dilemma in a discussion of the treatment of incest survivors by a fellow survivor:

Therapists who are also survivors may be especially susceptible to particular countertransference complications . . . (They) may assume a persistently masochistic position with patients . . . Another countertransference stumbling block for survivor/therapists may be a reluctance to allow themselves to be fully experienced by patients as bad objects. Uncomfortable with their own aggression and even more uncomfortable with any identification with their own abusers, clinicians may subtly, or not so subtly, defuse patients' aggressive transference reactions.

The traditional view has been that the therapeutic task is best facilitated when the therapist does not experience the same trauma as the patients. However, when 9/11 occurred, it was impossible to prevent those events from traumatizing both therapist and client. Thus, the countertransference was to be a central and difficult aspect of the clinical task of leading the groups as well as the consultation process.

CONSULTATION

Consultation and/or supervision are almost always helpful for the clinician treating traumatized persons because the countertransference is often intense, quickly changing, and compelling. Consultation from a trusted colleague assists the therapist in achieving and maintaining the necessary distance and objectivity to identify the countertransference. In our case, we were strangers separated by many miles and cultures (New York City and the Midwest). Contact was primarily via telephone and e-mail. The consultant worried about establishing trust without

face-to-face contact. A balancing act was required to obtain the optimal distance within a cocoon of trust. The leader had felt put off by the theorizing of those distant from the situation. As Alonso & Swiller (1993) have opined, mutual respect quickly overrode the inevitable "stranger" anxiety within the dyad. The consultant felt awed by the sensitivity and dedication of the leader in the face of such complicated adversity while the leader soon began to feel supported, assisted, and calmed by the consultant. As the work progressed, the consultant traveled to New York City, meeting the leader for the first time and, thus, the visual images and the experience of having met in person augmented the use of phone lines and cyberspace.

Prior to meeting with her for the first time, the leader was aware of and extraordinarily respectful of the consultant's clinical acumen and expertise in the area of trauma, having relied upon her text, *Fugitives of Incest: A Perspective from Psychoanalysis* (Ganzarain & Buchele, 1987) when working with male incest survivors in group therapy. The leader also spoke with other trauma therapists in New York City who were working with the same consultant, and each of us agreed that the consultant "got it" with respect to the trauma work we were doing, despite not being in NYC during the attack. At one point he wrote:

I feel held by your consultations in a way which allows me to hold the groups I'm leading. The subjectivity of 'emotional holding' is very subtle and very powerful, both for me and the groups.

COUNTERTRANSFERENCE AND CONTAINMENT

Almost immediately three aspects of the countertransference found their way into the work: (1) containing the group's anxiety and sadness as members talked about their experiences, which gave rise, in turn, to similar feelings in the leader; (2) managing direct and vicarious traumatization that were clearly present, especially in the leader; and (3) bridging the cultural divide between the leader and the consultant. Containment was a familiar function for the leader and consultant. As the leader wrote:

Feelings of disgust, horror, anxiety, rage, sadness, grief, curiosity arose while listening to the details as the group members described how they survived and what they saw and my reticence not to share all with my consultant, not wanting to traumatize her with what I had listened to and been exposed to.

And from the consultant:

I worked hard with my consultees. I felt conflicted as I asked for details about group members' experiences and stories. I knew how essential it was for the group leader to be able to share what he had heard and experienced, but I also felt I was gratifying my curiosity and that felt unacceptable. I inquired anyway, knowing from my own training and experience I was doing the best thing. . .

Clearly, each was trying to protect the other and each felt the strain of performing the containment function. As the process lengthened and deepened, the containment took hold. The leader wrote:

I felt very alone. Thank goodness for Bonnie. I didn't have Kohut or Kernberg with me. I didn't have Klein or Schermer, or van der Kolk or Herman with me. I had Bonnie and for that, I will be eternally grateful . . . Friends and family members don't want to and shouldn't have to hear the details of the work; colleagues were curious but exhausted . . . Knowing I could talk to Bonnie about the work and talk to her about things not about the work, provided me with the holding environment that was essential for me to proceed with the work.

From the consultant:

I think you are bearing witness and I am bearing witness to you. I think that for both of us that is a very good function. Please keep letting me know.

And a response from the leader:

The depth of the work is . . . extraordinary . . . members have shared their concerns and brushes with mortality, one man had cancer, an-

other lost cousins in Italy who recently died in an automobile accident and hadn't shared this with anyone. These groups are so moving . . . and have reached extraordinary depths of everyone's humanity . . . I asked myself why I choose to share this with you in an e-mail . . . and don't want a pat on the back or to be told that I'm doing a good job . . . this I know I am . . . it is in the sharing of the group's humanity, and frailty, and in describing how everyone relates to his own death and gives meaning to life . . . that leading this and other groups helps define and give meaning to mine . . . that, I believe, is the meaning of this sharing . . . that our work transcends our lives . . . and I am not always aware of the profound effect these groups have on everyone's lives.

VICARIOUS TRAUMATIZATION

Working with vicarious traumatization required more skill. While it was not the consultant's task to treat her consultee, identification of traumatization and supporting self-care behaviors was appropriate and helpful. The typical ways this occurred were inquiring how the consultee was feeling and coping, encouraging his taking time off, talking occasionally about matters other than the work itself, and strongly urging him not to work without monetary compensation. At times overcoming guilt associated with the rescuer's countertransference was difficult for the leader and overcoming fear of being experienced as a cold-hearted bystander was difficult for the consultant, a permutation of the transference/countertransference paradigm described in the literature (Buchele & Ganzarain, 1987; Davies & Frawley, 1994).

The cultural divide between the leader and consultant had its useful side. The geographical distance facilitated helpful objectivity. Coming from considerable distance and a differing aspect of American culture, the consultant was able to provide containment for the leader's feelings and at times assist in mitigating the intensity of the affects. When tornadoes endangered members of the consultant's family, they underscored the importance of this containing function; during that period, the leader noticed a shift/rupture in the consultant's emotional availability. Clearly, it was important for the leader to know that the consultant had the

emotional and physical distance from the trauma, (i.e., that she had not been as traumatized as he had and that her perspective was clear and usually accurate).

The cultural divide also presented some difficulties, however. Fearful of being seen as an unsophisticated outsider, the consultant initially found herself somewhat reluctant to mention matters that might evoke a negative response, for example noting the aggression in the transference or the countertransference or making comments that would expose ignorance about daily life in New York City. The cultural differences had the potential to inflate her survivor guilt as well. Also difficult for the leader, who lost family members during the Holocaust, was his sensitivity to and protectiveness of the consultant's feelings after she disclosed that there was German heritage to her family line.

The potential pitfalls presented by the cultural divide were softened by the pair feeling some trust and bonding emanating from their shared membership in a national professional organization that they both valued and respected. In addition, although a non-New Yorker, the consultant had more than the usual amount of acquaintance with and affection for the city and its inhabitants. In addition, the leader was familiar with the consultant's written work and had found it useful.

VICARIOUS TRAUMATIZATION—NUMBING

The following is an example of countertransference numbing that developed over time in the work with a group of employees from an agency based in the upper floors of the World Trade Center. The objectivity afforded by the cultural divide between group therapist and consultant seems to have helped to note the numbing and facilitate the work. The group had been meeting for over a year and a half when in consultation the leader mentioned that one of the group members, a quiet woman who frequently sat opposite the leader, had a very noticeable indentation in her skull and severe scarring around it. This woman had survived the journey down the stairs from her office within the twenty-minute win-

dow after the plane struck the tower. She wandered nearby and was caught in the huge dust cloud that developed as the building collapsed. She described feeling that she was "going to drown in the dust." Members of the group had worked in the same agency with this woman for over a decade prior to the attack. Throughout the group process, nobody, including the leader, had commented on or inquired about the obvious wound to her skull.

Only in consultation late in the group's life did the leader discuss her wound with respect to relating the group member's prior trauma history to her current traumatic response. There was an unconscious collusion among the group members and leader not to see, not to know, and not to ask about this very visible wound. But when the consultant suggested that the leader explore the origin of the wound, he did so, only to discover that she had fallen off a bicycle onto a road divider with a bolt protruding from it, which impaled her skull. The group members and the leader bore witness to her disclosing this for the first time in her life to anyone. It was a powerful moment in the group, as the member felt safe enough to disclose her painful experience.

SEVERAL CHALLENGING ASPECTS OF COUNTERTRANSFERENCE

Several aspects of the countertransference were especially challenging. Group members wanted to support one another and idealize the leader, wanting him to reassure them that good still existed in the world despite the horrific events that had occurred. Initially, this was helpful in establishing safety and cohesion. However, as in any homogeneous group, this positive regard and idealization eventually became a defense against exploring the aggressive feelings that trauma activates. To identify the terrorist within was like going into the belly of the beast.

The aggression within the transference and countertransference was manifest and explored in a number of interactions: when the leader was fired from one of the groups by the management; when the group raged at the management in

their workplace; and in the use of humor. While this part of trauma work is usually more difficult than other portions, it seemed especially difficult, possibly because the leader had also been subjected to the trauma.

When the management fired the leader, he wrote:

I hated it when one agency "disinvited" us from treating their staff. A shift in personnel a new person who made the decision to keep or dismiss us was at the helm. Do not minimize history when working in the here and now. This person hated therapy. The memory of a former negative experience in therapy so tainted him that when the decision to keep or dismiss us was his, it was not a difficult decision for him to make. I hated it! No chance to say goodbye to the people I worked with for months—Terminated.

When the group members raged at the leader, the consultant was there throughout, working with the leader on a regular basis. She might be driving across Kansas and he might be vacationing in upstate New York, but with a constant regularity, they spoke. The leader experienced the consultant as always having a clear clinical perspective,

Remember to pull for the negative transference. Find the terrorist in the group member.

And he did, which was challenging given that the idealizing transference to the leader conflicted with the members' need to express their own murderous rage. The leader noted that the group members often displaced rage onto the system in which they worked:

This company sucks . . . They are not protecting us . . . We don't get raises The alarm system said it was safe to go back to the building and go upstairs . . . Don't take the elevator in an emergency . . . Six elevator banks were under repair on September 11th. Would more people have been saved if they had been open?

With respect to the use of aggression in humor, on one occasion I had feelings of shame at laughing with group members in their

black humor as they composed a 9/11 list of "people who should have died rather than those that did." The leader wrote the following in response to one group's use of humor:

Laughter in the face of despair, humor to fill the void where buildings stood and colleagues worked side by side, year after year. Defenses against the cold, armed with a smile, a laugh to fight back the flood of tears, the outpouring of rage and hate. Humor to bind, humor to mend, to encapsulate, ameliorate, and emulsify the pain, the dread, the despair.

Joined together naturally, as colleagues, as friends, as grieving co-workers who observed the indescribable, who struggled down far too many flights of stairs to escape their demise; having to chose between attending multiple simultaneous funerals of dearly departed friends, colleagues, lovers, spouses, parents . . . this natural group used humor as the glue to hold together their fragmented psyches. Dark humor to heal from a very dark, life altering experience.

It wasn't funny. It was critical for the group to use laughter in a healing, transformative way.

Sometimes, the rescuer countertransference was strong in the leader. The leader identified with the suffering of group members and yearned to take it away. Well aware of his feelings, but respectful of the capacity for group members to help each other as well as the inherent power of the group to promote healing and growth, he often sat quietly, but warmly, during particularly painful times. Identifying the projective identification later during consultation seemed to reinforce the leader's confidence in inhibiting his impulses to rescue, which would have impeded members' growth. The rescuer countertransference seemed to be more intense than in other types of trauma treatment, possibly because of the mass nature of the trauma and possibly because of the leader's projective identification of his own victimization.

CHIDING INTERNAL VOICES

Disobeying the internalized voices of mentors and teachers stimulated worry about competence. Groups met under conditions

that were not ideal according to traditional group psychotherapy theory and practice. The leader had no control over group composition or the location of meetings. Interruptions and disruptions were common. Since the groups were all naturally occurring ones, outside contacts were the norm. Often everyone knew everyone except for the leader who was a stranger to all. How to think about boundaries was a challenge. Therapist self-disclosure was another sticky wicket; while it seemed helpful, it also seemed tantamount to "breaking the rules." The consultant was impressed with the leader's creativity in beginning some groups by passing his résumé around the room. This skillful use of self-disclosure helped to determine a group boundary, but felt like an outrageous violation of basic group psychotherapy tenets and framework. To discover in consultation that these interventions were creative and appropriate despite their initially appearing to be poor practice was crucial. We came to this conclusion by examining the rationale for these interventions, and by noting how they facilitated group process.

TERMINATION

As is the case in all trauma treatment, termination was complicated, especially in a group that lasted for an extended period and was essentially psychodynamic psychotherapy. It was painful for the leader to let go. While very impressive work had been done, it was clear in many cases that there was work yet to do. Moreover, the work had been so intense and compelling; "garden variety" groups were pale in comparison. Feeling the same pull, the consultant gently reassured him that being too protective might stymie group members' growth; further they knew they could contact him if they needed to. He said, "goodbye."

He loved them; he still loves them and misses them, people whose faces adorned magazine covers, frail, bloodied, and strong. He loved them . . . and he knew it. He never told them this, but he could not help but believe they knew it. A lifetime of memories frozen and fused in time.

Closure came to be a very important phase of recovery. They continue to integrate what happened into their views of themselves, others, and the world. We do too as we write our experiences.

REFERENCES

- Alonso, A., & Swiller, H. (1993). *Group therapy in clinical practice*. Washington, D.C.: American Psychiatric Press.
- Davies, J., & Frawley, G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York, NY: Basic Books.
- Ganzarain, R., & Buchele, B. (1987). *Fugitives of incest: A perspective from psychoanalysis and group*. Madison, CT: International Universities Press.
- Phillips, S. (2003). *Countertransference: Effects on the group therapist working with trauma* (unpublished manuscript).

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