

Athens



**Psychotherapists,
aggression and violence**

... risky business

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Mark Luyten

Psychotherapists, aggression and violence, risky business.

Hello. My name is Mark Luyten. I am from Belgium where I have a practice as a Gestalt psychotherapist, counsellor, coach and supervisor.

A large majority of the individual clientele is (sexually) traumatized. A large part of the professionals I see works with these clients.

So aggression and violence are frequent topics in my work.

A fast growing group of clients is the group psychotherapists who suffer burnout or secondary traumatization.

In our therapeutic work we encounter aggression and violence on a daily basis. The difference between the two concepts is – especially in spoken language – rather vague. They very often are used in the same sense and seem to be interchangeable.

Agression and violence (1)

- aggression =
 - an emotional state
 - a state of awareness

- violence =
 - behaviour
 - what we do

The difference I explain to my clients is that I see aggression more as an emotional state, as a state of awareness, while violence is more a behaviour, something we do. And between the two there is a certain grey area where aggression turns into violence and vice versa. Due to cultural, ethical, political and religious influences the roadmap of this grey zone is very unclear and there is a lot of discussion going on about which way we should take.

Agression and violence (3)

aggression

culture
ethics
politics
religion

violence

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4

So we discuss about terrorism, about the death penalty, about physically sanctioning our children. And what is considered violent behaviour to one person, is acceptable to another.

One of my clients is a young mother who got pregnant again. Her baby was born when she was 24 weeks pregnant. The paediatrician refused to start care for the baby because in my country a premature baby has to be 25 weeks to receive medical care. The perfectly healthy baby lived for three minutes. Then the umbilical cord was cut and the baby died.

For the mother, this is cruelty, pure horror. For the doctor this is good practice.

Agression and violence (4)

- Perls:
 - (dental) aggression as a condition for creativity
 - aggression is energy
- “The ability to express ourselves and to create”
- Ad gredere: to go to

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5

I think that Perls was right when he described aggression as energy, as power, as the engine of creativity. Aggression in the ancient meaning of the Latin verb *ad-gredi* means that we have “the ability to express ourselves and to create”? But uncontrolled aggression can turn into destructive violence. So the notion of aggression causes a lot of restlessness and agitation within our clients. To many people aggression is not a positive notion. It is not a constructive concept. At the contrary, they very often see it as the cause of their troubles and pain. It is to be avoided, banned. It is considered an improper answer. These clients are introjected with rules that prohibit not only violence (this is most of the time justifiable) but also aggression and many acceptable forms of behaviour such as: assertiveness, expression of one’s opinion, asking for information, imposing or confirming

justifiable boundaries, expression of any kind... The goals and tasks are adjustment and avoidance... The result is very often deflection, retroreflection, compliance, and also fear and anxiety in the first stage and violent behaviour (internally or externally) later on. So violence very often not originates in aggression but in the inability to be aggressive, in the way Perls saw it.

In other clients we do not notice this resistance. In their behaviour they show a lack of respect for boundaries, they are sometimes very violent and abusive. For them violence is a well accepted answer, well integrated in their personality functioning. The best short cut to the gratification of their needs. But it also indicates pathology, a destructive field organisation. The therapeutic demand mostly originates in the context of these clients. It is not their need. A judge decided that therapy was necessary, their spouse threatened with divorce or their employer with resignation. The client wants to avoid these malice's and begins therapy. Nice gift, isn't it?



In our work – especially when we work with trauma clients – we are very vulnerable and the constant confrontation with the violent stories of our clients can cause harm. At the other hand clients themselves can be very violent as well. These clients can and will hurt us.

Violent clients

I really do not remember all the violent stories clients told me in the 27 years I work now as a therapist. The moments however where I was directly violently approached by a client are very clear in my memory. I recall these moments with an astonishing precision. These moments claimed an absolute awareness for I was threatened. Sometimes it is just acting out. We respond adequately and that is that. Sometimes however the experience is not put aside that easy. For instance: I was beat black and blue by three juvenal delinquents. Two colleagues stood by and watched. The principle refused to punish the offenders and called it professional risk and advised me, and I quote "no longer to provoke them". This experience had many levels and influenced the entire social field I participated in. It also changed my attitude. I became much more aware of the danger and took less risks, did no longer blindly trust my colleagues and lost my faith in the

principle completely. But it also changed me. How I looked at myself and at the world.

Sometimes the violent experience lasts for a long time. A female client stalked me for more than two years. Telephone call's, letters, she consulted colleagues and told all kind of stories about me. She also gave me this drawing. I am quite convinced that the scratches on my car were her work. It ended when I threatened to press charges.

Ego-document



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Clients

- Violent **clients**
- Violent **stories**

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Violent stories

Clients tell us about their pain, about the violence they were victim of. We listen to these stories because it is our job. Our capability to listen is the instrument we use in therapy. But we not only listen, we not only register but we also empathize and include. We let in not only the story but also the experience. And we don't do this once but every time, time after time, several times a day. How much can we handle? It is a very simple question, but is the answer as simple?

Attitude (2)

- Acceptance
- Listening
- Containing
- Empathizing
- Including

} Experiencing

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Clients

- Violent **clients**
- Violent **stories**
- Violent **therapists**

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What is the influence of our work on the quality of our lives?

Well, most of us report an increase of self-confidence, increase of sensibility and alertness. We also report more personal growth and relationships which are more real, genuine and profound. So there is a clear profit. Our job contributes to our wellbeing, our happiness.

Benifits



- Increase of **self-confidence**
- Increase of **sensibility** and **alertness**
- **Personal growth**
- Relationships more **real**, **genuine** and **profound**

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10

But a large number of therapists is not so lucky. They report burnout, compassion fatigue, secondary or vicarious traumatization and other problems.

Costs



- Therapists have **more** than an general population **psychological problems** and they **do not recognize** this or certainly **not in time**.
- 25% of the American psychiatrists describe themselves as **suicidal**. 1 out of 16 attempted suicide.
- 82% of the therapists report **marital problems** (divorce ratio: 51%)
- psychotherapist report **low emotional investment** in their own family
- After 25 year almost 1 out of 2 psychotherapists experiences his or her **professional live** as **unsatisfying**
- More then in other professional groups psychotherapists **doubt** their **choice of career**.

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11

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Secondary Traumatization (1)

- Indirect experience of a trauma through the process of being a witness to another person's story
- Normal, inevitable
- Effects can be modified or reduced

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13

Secondary Traumatization refers to the effects of working with people who have experienced trauma. In the therapy process we are exposed to the traumatic stories they share with us. It is called secondary traumatization because the trauma is experienced indirectly, through the process of being a witness to another person's story. Secondary Traumatization is a normal, inevitable part of working with individuals and groups of people who have suffered major losses or experienced terrible events. It cannot be avoided or eliminated, though its effects can be modified or reduced. Secondary Traumatization is often a slow, cumulative process that occurs over the course of hearing many personal stories of tragedy, loss and pain.

Secondary Traumatization (2)

- Secondary Traumatization is a **slow, cumulative** process that occurs over the course of hearing **many** personal stories of tragedy, loss and pain

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14

Other models

- compassion fatigue (Figley)
- vicarious traumatization (Pearlman & Saakvitne)
- soul sadness (Chessnick)
- secondary traumatic stress (Stamm)

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15

Mostly in the nineties a lot of theories are developed that give us some terminology and knowledge of the phenomenon.

- compassion fatigue (Figley)
- vicarious traumatization (Pearlman & Saakvitne)
- soul sadness (Chessnick)
- secondary traumatic stress (Stamm)

While these terms sometimes differ in their focus, they share in common a recognition of the stress experienced by workers who encounter human suffering on a regular basis. The stress takes a toll.

Secondary Traumatization can take many different forms, depending on the individual and the work environment. Psychologists and nurses in the same

psychiatric institute experience the situation differently. So it is difficult to draw one line. It is also difficult to produce an exhaustive list of signs and symptoms.

So I would like to present a case to you that illustrates the effects on the way we function. Its only one case and every case is different.

Case (1)

1. Numerous stories about incest
2. Intrusion of work related issues in private life
3. Offender is an acquaintance
4. Ethical dilemma
5. Eating problem, sleeping problem,
6. Isolation, avoidance
7. Safety shift
8. Intrusive thoughts and images
9. Low self esteem, self criticism

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15

The client tells her story in the intake interview as follows:

As a psychotherapist I listen on a daily basis to **numerous stories of incest** survivors. I knew how to cope. And then, Carla, a 10 year old friend of my own daughter told her story when she was playing **in my garden. I knew her father**, saw my daughter on his knee, last summer.

And later that day I had to bring Carla back home. Leaving her behind was **the most difficult thing** I ever did. I **couldn't** eat, sleep, concentrate... I **isolated** myself, **avoided contact**. And this lasted for days. I became **overprotective** to my own children en very suspicious to all men. I got reflux, and developed speaking problems.

In the weeks that followed **other stories came into my mind**. Sometimes stories of many years ago. In my dreams I got fragments of stories clients told me. And every time my conclusion was that **I had acted poorly** as a psychotherapist. I became **my own greatest critic**.

One day I told Carla's mother what had happened in my garden. She was shocked but also saw a suspicion confirmed. I advised her what to do. That night I could sleep again, without nightmares. But a lot of the complaints remained, didn't go away.

This is one of the many cases I worked with. Here the story only begins. In the weeks and months I worked with this client we explored the field organisation and we found the fundamentals for her problem. Carla's story was only the trigger. The real issues were the disturbances in the ID, EGO and Personality Functioning of this client. For years she did not register her own bodily and emotional signs (**ID**). Her own needs were minimized or ignored. She over-identified with suffering people. This was facilitated by the fact that she worked with traumatized children and by the fact that she herself was parentified in her own family. The younger they are the deeper the knife cuts (**EGO**). She got **fixated** in a specific coping style that excluded a lot of healthy coping processes and forced her time after time in the

same behavioural pattern: helping where ever she could. And then she ran out of energy.

Case (1)

- ID
 - Own bodily and emotional signs are not registered
- EGO
 - Denial of her own needs
 - Over-identification
- Personality Functioning
 - Exclusion many coping strategies
 - Fixation on specific coping style (= helping)

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24

Gradually secondary traumatization wears us down. Eventually, if it is not properly addressed, it can leave us **exhausted**. Once we are exhausted, we are **unable** to listen well, to make sound judgments, to think clearly, or to help others. In addition, qualities such as **cynicism**, **disillusionment** and **despair** can become a permanent part of our identities, of the way we act on the contact boundary.

Secondary Traumatization: some effects

- Exhaustion
- Diminished capacity
 - to listen
 - to make sound judgement
 - to think clearly
 - to help
- Cynicism
- Disillusion
- Despair

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25

Vulnerability

Why are we so vulnerable? Are there specific reasons or is this all coincidence. One of the explanation models is that psychotherapists more then others are socialized to be an unselfish saviours who ignore their own needs to fulfil the needs of others and who learn the skills that make this possible.

The **cliché** that students choose psychology as their major to get answers to all the questions they have about themselves, isn't so wrong.

Psychology Student data

- More interpersonal stress
- In their original family more:
 - Depression
 - Schizophrenia
 - Alcoholism
 - Character distortions
- They play triangulated roles
 - Carrier of burden, go-between, scapegoat, butt, lightning conductor, entertainer
- Parentification
- Narcissistic motives

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26

These students experience more than others interpersonal stress
In their family we find more than in other families:

depression
schizophrenia
alcoholism
severe character distortions

They played the role of
carrier of burden
go-between
scapegoat
butt
lightning conductor
entertainer

Parentification (but without acknowledgement)
Narcissistic motives

I truly believe that this background is not a counter-indication to take up our profession. It can even make us more fit to be a therapist. But it also makes us vulnerable. Especially because it very often involves the adaptation of inadequate coping mechanisms and coping strategies which we apply in our professional life.

The way we undergo the effects of constantly listening to traumatic stories depends on several **factors**:

- trauma characteristics: heavy stories have heavy consequences
- client features:
 - age, sex
 - young, vulnerable and powerless = more impact on the helper
 - suicidal, auto mutilation, addiction = more impact
 - transfer situations = more impact
- therapist features:
 - poor coping strategy
 - juniors
 - pioneers
 - female

- traumatized (recognition, identification)
- end of the line function

Risk features (3)

- trauma characteristics: heavy stories have heavy consequences
- client features:
 - age, sex
 - young, vulnerable and powerless = more impact on the helper
 - suicidal, auto mutilation, addiction = more impact
 - reference situations = more impact
- therapist features:
 - coping strategy
 - juniors
 - pioneers
 - female
 - traumatized (recognition, identification)
 - end of the line function

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29

All these features have influence on the appearance of the problem. Some of these features can be addressed in therapy, others demand organisational policy. But let us look at the coping strategies.

Coping mechanisms

Healthy coping strategies can be either involved or standoffish. Our response to a stressful event is a mix of four basic reactions:

- inclusion: sharing, rapport, matching, I-YOU contact, understanding
- empathy: co-experiencing, identification
- professionalism
- stimulating responsibility: the client is a self regulating organism

A mix of involved and standoffish behaviour, but with enough overlap so that we can speak of a therapeutic relationship characterized by recognition, acceptance and equality. The three necessary qualities of the dialogical relationship a therapeutic relationship should be.

Healthy coping reactions

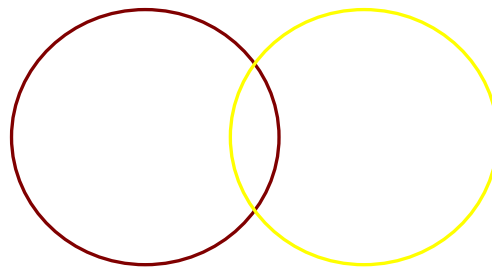
Involved **Standoffish**

Inclusion	Professionalism (craftsmanship)
Empathy	Stimulating Responsibility

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27

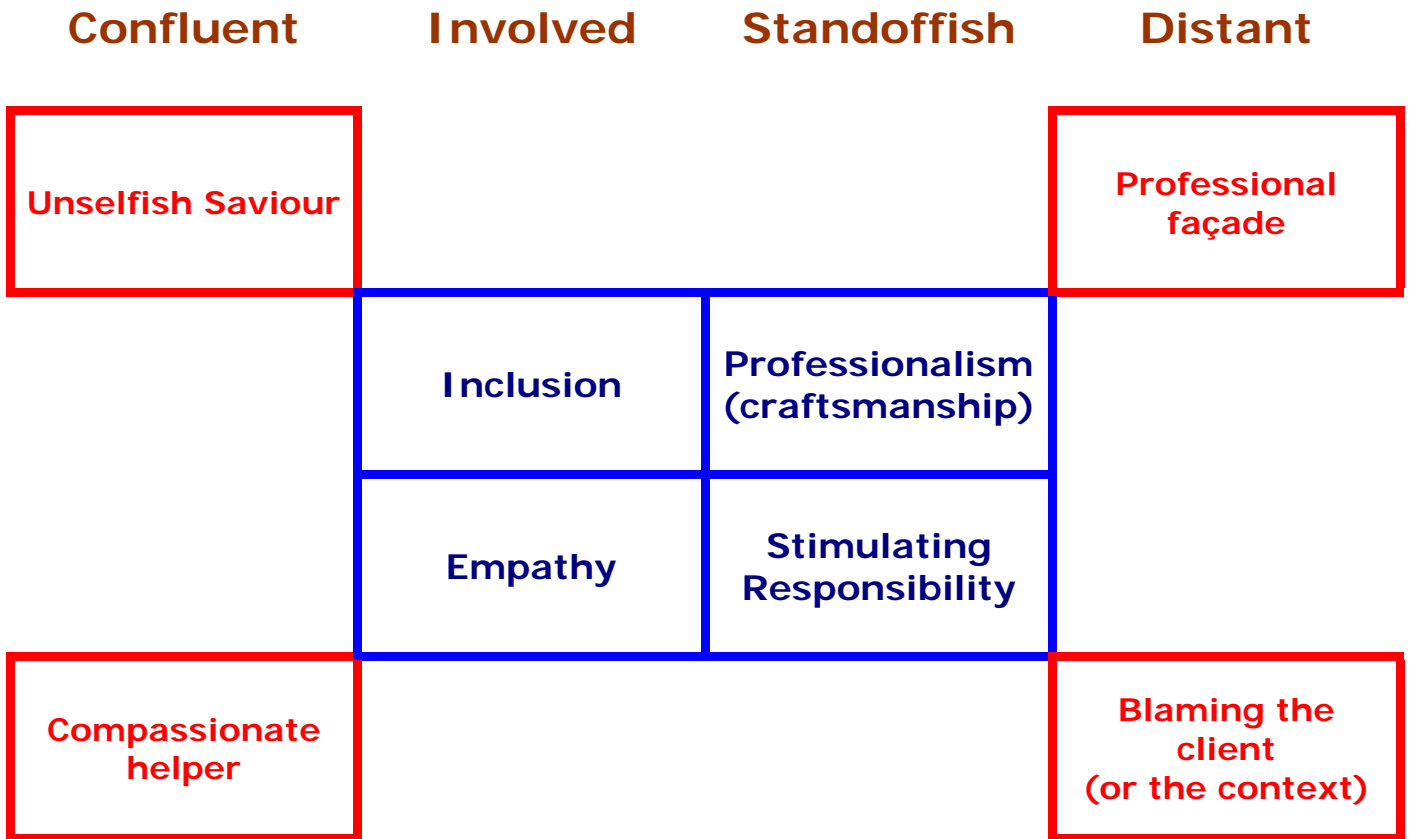
Blue zone: healthy coping styles



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28

But the vulnerable helper also learned other strategies. If we learned to put our needs aside, always to say yes, to dissociate from our emotions... so that we could maintain ourselves in very stressful situations, than we will apply these strategies also in our therapeutic work. And don't forget that also in our professional environment we are introjected with rules, values and convictions that push us to go beyond our own limits.

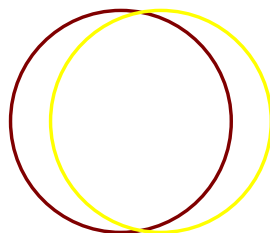


We end up in the red zone. Now and then is not really a problem, but when we are constantly in this zone we will undergo the effects and after a while diagnoses as burnout and secondary traumatization are inevitable. These are high risk occupational diseases.


If we get to involved and inclusion and empathy are exaggerated , we become an unselfish saviour or a compassionate helper. **I and You become WE**. The unique identity disappears. In the therapeutic process there is over-identification, a lack of professionalism and the own answers and solutions are projected on the client.

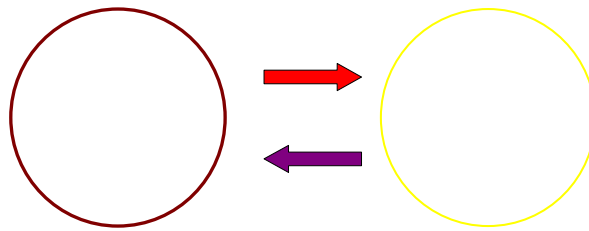
Confluence: fusion, merger, symbiosis


I = You = WE




An over-involved coping reaction is often compensated by the polarity, the opposite coping strategy. To do so we have to struggle. And so an over-involved coping strategy can be replaced by an over-standoffish, a distant position. To free ourselves we fight (blaming) or flight (professional façade).

Blaming, struggle, fight 
I against You



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24

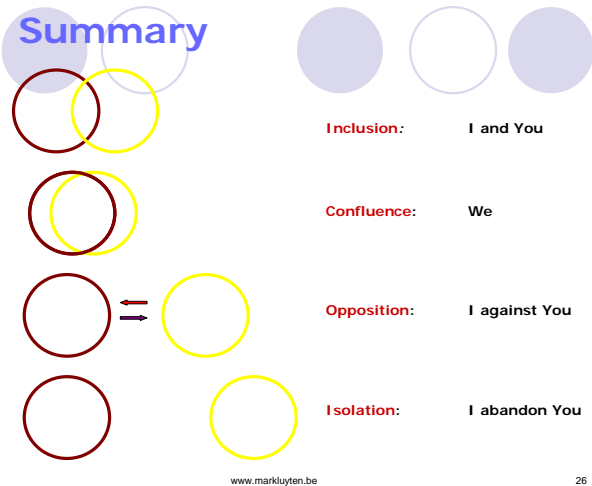
Professional façade, abandon, flight 
I abandon You



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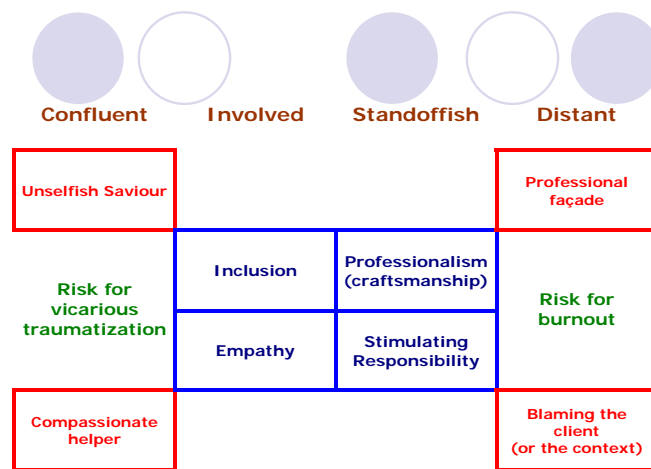
25

Summary



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26



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27

In the case of **burnout**, where the emphasis lays on the (mainly physical) stress reaction due to an overload of work related stressors (to many clients, to many difficult clients, not enough time, bad working relations, not enough pay), the solution very often is reduction of the stressors. This can happen by going on sick leave but this does not structurally change anything. The field should really reorganize as well on the micro, the meso as the macro level. Then new field conditions are created and real prevention and handling takes place.

In case of secondary traumatization the impact of the process is more profound. It reaches the level of our self image and the image of the world (the others) we have. The changes are more of a conceptual nature and more difficult to turn around.

Of course many colleagues with problems show signs of both burnout and secondary traumatization.

In my practice most of the **burnout** clients can stay in their job if their attitude towards work (internal) and their work environment (external) change. But in case

of **secondary traumatization** the situation is more complex. 50% of these clients make a career shift. And half of those who stay change their job. So only 1 out of 4 psychotherapists with secondary traumatization complaints hold out in their present job. 3 out of 4 don't, and that is a lot of training, expertise getting lost. Not only the individual psychotherapist but also society as a whole pays a very high price.

Numbers



● **Burnout:**

- 95 % stay in office if working conditions change

● **Secondary Traumatization**

- 50 % make a career shift outside the non profit sector
- 25 % make a career shift but inside the non profit sector
- ONLY**
- 25 % stay in office

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42

So if we can do something about it. Please let us. Prevention is the message. Treatment is necessary but the emphasis should lay on organising the field in such a way that psychotherapists will not get harmed doing their job. The responsibility is partially individual but is also a shared responsibility. The organisations we work for and the community as a whole have a responsibility too.

What can we do? Prevention is better than cure!!!!

Training institutes very often present their success stories. They show off with their knowledge and their skill. So trainees sometimes think they are almighty and can do everything. A good training facility is concerned and does not avoid talking about the downsides of the job. Their trainees know the risks and how to recognize and address them.

Prevention



● **Training institutes:**

- Not only succes stories
- Info about risk
- Attention on coping

● **Employers and colleagues:**

- Training facilities, intervision, supervision
- Correction, alertness for signs of sec. trauma.
- Job variation, job rotation
- Combination work and private life
- Appreciation

● **Partner, children and friends:**

- Mandated to intervene

● **Self care:**

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29

On the **work floor** specially when we work in a team, fraternal consultation and intervision and supervision are very good instruments. The employer should provide in adequate training and specialisation possibilities and should provide the proper materials to do your job. They should facilitate job variation and job rotation. My employer has to intervene if I see to many clients, or to many clients with the same problem. I should be able to contribute to the organisation (not just do my job), to be creative. Employers can also facilitate the combination of professional and private life (shifting ours, family friendly working hours). Appreciation of any kind is a very powerful drug and we never overdose.

I give my **partner, children and friends** a mandate to intervene, to point out to me where my responsibility lays. My responsibility as a partner, a father and a friend. I and those that are very near to me, see to it that I have a life outside my therapy room.

But we have **our own responsibility** as well. A lot of us do not work in an organisation and have to take care of our selves. We have to organize our own self-care. We do this by recognising our own needs and by respecting our boundaries. We do not work too much, we keep our selves in the blue zone. We keep in touch with friends and family and we are active in solving eventual problems in that field. We are unselfish, we support social projects, we serve society. We stay interested in culture, art and spirituality and if possible are active in these fields. We are part of intervision and supervision groups, we study and read and try to improve our professional skills. We take care of our health, our body and physical condition.

Self-care

Angeline Donck, a Dutch colleague developed an instrument to measure our self-care. I adjusted it and now also translated it. She points out 5 aspects in self-care.

1. **Physical** self-care
2. **Psychological** self-care
3. **Emotional** self-care
4. **Professional** self-care
5. **Balance**

Physical selfcare

1. I eat regularly (breakfast, lunch, diner) and healthy.
2. I have physical exercises.
3. I have preventive medical care.
4. I have medical care if necessary
5. I go on sick leave when I am sick.
6. I have massages.
7. I dans, swim, walk, run, sport, sing or other amusing physical activities.
8. I take time for sex with myself or with a partner.
9. I get enough sleep.
10. I carry the cloths I like.
11. I take vacation
12. I make daytrips and take short vacations
13. I put the telephone of the hook

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33

Pshycological self care

1. I make time for self reflection.
2. I am in psychotherapy.
3. I have a diary.
4. I read stuff that has nothing to do with work
5. I do something without being an expert or responsible
6. I reduce stress in my life
7. I pay attention to my inner experience: my thoughts, my opinions, my convictions and emotions.
8. I show different aspects of my self.
9. I connect my intelligence with new areas: art exposition, sports event, theatre, etc.
10. I practice accepting the attention from others.
11. I say – now and then – no to new responsibilities.

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34

Emotional self care

1. I spend time with others if their company is amusing.
2. I stay in contact with the important others in my life.
3. I compliment my self,
4. I appreciate my self.
5. I love my self.
6. I read my favorite books again, I like to see good movies again.
7. I discover amusing activities, people, objects, relations, places and look them up.
8. I allow my self to cry.
9. I look for situations and people where I can laugh.
10. I show my indignation in social actions, letters, donations, protest, demonstrations.
11. I play with children.

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35

Professional self care

1. I take brakes during a working day (ex. lunch).
2. I take the time to talk to colleagues.
3. I take the time to finish assignments.
4. I find out wich projects and assignments are exiting and rewarding.
5. I impose boundaries to my colleagues and clients.
6. I balance my case load so that no day or part of a day becomes too heavy.
7. I furnish my work space so that it is comfortable and agrees with me.
8. I am in intervison and supervision.
9. I negotiate with my employer about my professional and financial needs.
10. My colleagues are supportive.
11. I am professionally interested in other domains then trauma.

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36

Balance

1. I aim at a balance in my professional life and my working day.
2. I strive for a balance between work, family.

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37

Doncks presents a number of actions we can perform. We do these actions:

- Often
- Sometimes
- Rarely
- Never
- Not applicable

With “often” you score 5 points, with “sometimes” 4 points. You add your score per item. And than you compare with the possible maximum score. The interpretation

is yours to make. Interpersonal comparison is useless for this is a self-description instrument.



- Physical self-care: max. score is 65 score 4+5 =
- Psychological self-care: max. score is 60 score 4+5 =
- Emotional self-care: max. score is 50 score 4+5 =
- Professional self-care max. score is 55 score 4+5 =
- Balance: max. score is 10 score 4+5 =

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39

It is remarkable how poorly psychotherapists score. Especially in the field of psychological, emotional and professional self-care.

The advantage of this list is twofold. It describes the situation as it is and indicates at the same time what we can do to improve. This list can be used in an individual setting as well as in a group setting (team, organisation).

Conclusion:

Our job is a very beautiful and rich experience. But it also can become painful and threatening, hazardous to our health and welfare. We can prevent most of this and cope with the rest. But only if we go the experience the whole way, when we stay in contact with ourselves and with the others. Aware and conscious that we do this job not only for the benefit of others, but also for the benefit of ourselves.

Thank you.