Moral Dimensions of Trauma Therapies

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Psychotherapy is a unique social relationship, generally taking place over time between two (and at times among more) people. It “…can be viewed as a form of specialized social interaction….” (Doherty, 1995, p. 35). One important aim of psychotherapy is for individuals to explore their foundational beliefs and worldviews. In his outstanding slim volume, Soul Searching, Doherty (1995) noted that “…morality in psychotherapy … [is] a delicate blend of clarifying, exploring, thinking together, and occasionally challenging” (p. 186). Because psychotherapy relates to human welfare, every aspect of it has moral dimensions. Others have written about moral issues in psychotherapy more generally, but these issues have not been examined in depth as they relate to trauma therapies. (See Thompson [1995] for a discussion of moral issues in trauma research.)

In this chapter, I hope to increase morality researchers’ and trauma therapists’ awareness of the moral dimensions of clinical work. This consciousness may help guide decisions related to many aspects of treatment that therapists typically view from clinical and/or interpersonal perspectives. In the first part of this chapter, I address three moral issues that arise in psychotherapy with trauma survivors which have important moral dimensions. In the second part, I explore the therapist’s possible moral transformation through working with people who have experienced violence or victimization. Many of these issues, while particularly relevant to
trauma therapies, also apply to human relationships more generally and so may be of interest to social psychology researchers.

I define morality as a dynamic relationship with principles and virtues, reflected in beliefs and behaviors that affect others’ welfare. By “dynamic relationship,” I mean that our morality can be authentic only when we are constantly reviewing our values, our actions, our own and others’ needs and feelings, and the situations in which the need to make moral choices exists. Morality comprises both cognitive and affective elements, as several chapters in this volume explain. Here, rather than adopting a relativistic stance, I wish to emphasize the developmental, relational context that should inform moral choices or judgments.

Moral attributes such as empathy, compassion, acceptance, tolerance, kindness or caring, integrity, honesty, reliability, mutuality, courage, respect, and generosity are the building blocks of moral principles. Thus, for example, the attribute of empathy underlies the principle that we should relate to therapy clients with open-mindedness, sensitivity, and respect. Elsewhere, my colleagues and I have written about empathic connection as having two aspects: cognitive and affective (Pearlman & Saakvitne, 1995). This conception of empathy is consistent with that of Baron-Cohen (2005), who wrote, “Empathy is about spontaneously and naturally tuning into the other person's thoughts and feelings, whatever these might be” (p. 168). The cognitive aspect of empathy has to do with understanding the other’s experience and perspective. The affective aspect concerns one person’s appropriate attunement and emotional relation to another person’s emotional states.

This ethical empathy principle (relating to clients with sensitivity and respect) in turn gives rise to behaviors, including the therapist’s best efforts to attune his or her awareness and sensitivities to the survivor client’s experiences of violence and victimization, to the client’s
current life situation, to the complexities that interfere with efforts to process and integrate
trauma while fulfilling daily obligations. Moral judgments flow from principles. Following the
empathy example, a therapist might negatively judge a client’s behavior when she, a mother,
humiliates her child when the child does something the client dislikes, while also continuing to
seek compassionate understanding of both the past and present circumstances that are the context
for her parenting behavior and to find ways to guide the client toward more empathic and
respectful treatment of her child.

*Moral Issues in Psychotherapy with Trauma Survivors*

Given the large number of clients who have engaged in psychotherapy (approximately 30
percent of the US population had been in psychotherapy when Doherty wrote about it in 1995),
and given its potential to shape the way individuals relate to others, it seems important to reflect
on its moral dimensions. In this section, I address the following aspects of trauma therapy in
which moral concerns are central: managing frame and boundaries, helping a client move toward
a greater sense of moral agency, and attending to countertransference and vicarious
traumatization. I have chosen these three issues because they are particularly salient in trauma
therapy, and because their management has the potential to promote recovery or to cause harm.

Moral matters such as suffering, shame, guilt, justice, truthfulness, caring, and
community, which can enter any relationship, are especially likely to emerge in psychotherapy,
and they will likely emerge with greater intensity in therapy with people who have experienced
early or severe violence, abuse, or neglect. This intensity is related to the affectregulation
problems that many such “complex trauma” survivors endure. They often feel their emotions
more intensely than those whose development has not been shaped by violence and
victimization.
Managing Frame and Boundaries

The frame and boundaries of a psychotherapy relationship are a series of agreements that the therapist and client reach in their work together (Pearlman & Saakvitne, 1995). In every interpersonal relationship, we develop a frame and boundaries. In psychotherapy, these agreements relate to how the therapy will be conducted, including treatment goals, frequency and duration of meetings, payment arrangements, the participation of third parties, therapist self-disclosure, confidentiality, forms of address, and so forth. These issues are extremely important because they define the relationship and facilitate (or hinder) treatment outcomes. In this section, I will not address the clinical, ethical, and legal perspectives on frame and boundary issues in trauma treatment, because they have been addressed extensively elsewhere (e.g., Brown, 2008; Courtois, 2010; Pearlman & Saakvitne, 1995; Pope & Vasquez, 2001). I am interested here in examining the moral dimensions of frame and boundaries. I differentiate therapy-related “ethics” (a system of principles that govern appropriate behavior, usually codified by professional associations or administrative bodies) from “morals” (one’s internal dynamic relationship with principles and affect governing therapy-related behavior).

The frame reflects the therapist’s theory of change. For example, a cognitive-behavioral therapist might propose a time-limited therapy, focusing on the client’s current life circumstances, behaviors, and cognitive distortions. In this therapy, lengthy examination of the client’s childhood history is not within the frame, because it is not relevant to the therapist’s formulation of how change will come about.

Frame issues are crucial in therapies with survivors of interpersonal victimization because the harm they have endured likely occurred in the context of a violation of boundaries. Individuals who have experienced betrayals or abuse in important relationships will be
particularly sensitive to boundary violations. Often, someone has intruded on the survivor’s body and his or her emotional, psychological, or spiritual space, privacy, or integrity. Adult survivors of childhood abuse and neglect often arrive in therapy with fear or suspicion about the therapist’s interests, motives, and behaviors. This suspicion grows out of experience with others who were supposed to look out for the welfare of the individual but dramatically failed to do so, and who also betrayed the client’s trust and violated his or her boundaries. These violations most often involve a loss of control by the victim, resulting in helplessness, fear, guilt, and/or rage. It is not unusual for a survivor of childhood interpersonal violence or victimization to begin therapy prepared to protect him- or herself from the therapist. Early conversations about boundaries have the potential to alert the client that things will be different in this relationship: boundaries will be discussed, negotiated, and, if the therapist behaves competently and ethically, honored.

Helping the Client Evolve to Moral Agency

A therapy client who had experienced war-related trauma once told me his goal was to move from victim to victor. Initially, I was uncomfortable with the possibility that “victor” might mean “aggressor” to him. Fortunately, this was not the case. He was talking about being a positive actor in his life rather than the object of others’ harmful actions. Doherty (1995) and Kottler (2010) have both written about the therapist’s role in encouraging clients to develop their moral perspective. This is initially delicate work with persons who have been subjugated to others’ will and suffered as a result. The survivor client’s moral perspective initially may focus on himself as the victim, the injustice of what was done to him, and his valid needs for acknowledgment and restoration. In time, with adequate empathy, compassion, and support, the client can begin to broaden his perspective to include a greater understanding of the context of his victimization. This often allows him to become interested in understanding why the
perpetrator engaged in harmful behavior, and why the perpetrator chose him for abuse, neglect, or other forms of victimization.

In cases of child maltreatment, the therapist can eventually invite the client’s opinions about the harm doer’s motivation. What kind of childrearing did the harm doer experience? Where did he or she learn to use power over others in this way? This exploration is not intended to excuse the harm doer from responsibility. Instead, its goal is to help the survivor client integrate what happened into a broader context: What is the larger family history, social context, and cultural meaning of the harmful events, including the way others did (or did not) respond to the client’s needs at the time.

Some (although not most) who have been the objects of aggression will turn aggressively against others who are more vulnerable. For some abused children and adolescents, this takes the form of bullying or harming younger siblings, pets, or children for whom they babysit. This behavior may be understood in a variety of ways, for example, as modeling, attempting to assert control to compensate for the lack of control in other situations, discharging aggressive impulses, identifying with the aggressor, or reliving the traumatic experiences in a different role as a path to mastery. Whatever the reason, trauma therapists who work with survivor clients encounter a moral opportunity when the client reports or suggests that he or she may have harmed others. Doherty (1995) points to the value and challenges in helping the client explore his or her role as a potential agent of injustice rather than only as a victim (pp. 49ff). He asks, “When is it appropriate to introduce the discourse of justice and fairness in talking about client behavior that is morally, though not legally, suspect?” (p. 52). The answer of course depends in part on the strength of the therapeutic relationship and in part on the level of harm the client is inflicting on others. Harm against children and elders must be stopped and, in most states in the U.S., must be
reported as soon as the therapist is aware of it. Serious harm to anyone must also be stopped. But
the therapist must use clinical acumen to ensure that it is the harmful behavior, and not the
therapy, that the client brings to an end. Transparency on the therapist’s part, combined with
compassion for all parties, can provide a foundation for managing such difficult therapeutic
challenges.

For example, upon learning that a client was engaging in harsh physical punishment of
her son, one therapist opened a discourse about how challenging child-rearing is, how
demanding the client was finding the child, and whether this form of punishment was working.
The therapist also said that he was concerned about the physical and emotional harm the
punishment might be doing to the child, and that he was certain the parent wanted what was best
for the child as well as for the family. The conversation soon moved to an exploration of why the
son’s behavior might be worsening, whether there might be a more effective way to address his
behavior problems, and the need to find another way to work with the child to ensure everyone’s
safety. The therapist explained to the client that he was legally obligated to report to the State
instances of child abuse, and that the type of punishment the mother was using might well meet
the state’s definition of abuse. This discussion opened many paths for the therapist and client to
explore. The mother was distressed and surprised that the therapist thought the son might be
experiencing harm or even abuse. Her initial fear and anger passed as the therapist helped her see
the connection between her behavior and the harsh parenting she received as a child. She was
stunned to realize that she was doing to her son what her own mother had done to her. The
therapist invited the client to bring the son into the next session, which the mother did. This gave
the therapist an opportunity to observe the dyad’s interactions and to initiate a family therapy
referral. This entire process extended over only three sessions. The longer-term work included
opportunities for the therapist and client to discuss what kind of parent and what kind of person she wanted to be: how she wanted to relate to others in her family, community, and society, and how she wanted to view herself as a mother. Doherty also provided an extended example that serves as a lovely illustration of the process of inviting the client to examine his or her own role as a moral agent (1995, pp. 49-54).

How can a trauma therapist help a client move toward moral agency? For many survivors of interpersonal victimization, action is fraught with challenges. The fear of punishment can be very strong in people who were victimized as children. Passivity is a well-known survival strategy for many if not most children who grow up in unpredictable, violent homes or communities. Being invisible and squashing one’s own needs and feelings are ways children try to avoid harm. In adulthood, then, the difficulty of being an agent in one’s own life is enormous. If action is to be based on empathy, compassion, and an accurate assessment of psychological needs, then the first step is for the client to have access to his or her emotional states. Developing this access can open up a deluge of unprocessed pain.

These vital survival strategies—emotional numbing, self-denial, inhibition—often result in deep resentment and rage. It takes a great deal of emotional work to suppress needs and feelings over time, and the result can be serious emotional, physical, and spiritual deprivation. The essential warming of a frozen emotional life is often accompanied by much pain, parallel to the experience of frostbitten hands or feet beginning to warm.

In addition to learning to experience, recognize, and tolerate feelings, the survivor must overcome the fear that expressing a need will be met with rejection or punishment. This process requires cognitive-behavioral intervention and the processing of affect, built on a solid foundation of connection with the therapist and social support that may need to be acquired and
developed. (See Pearlman, Rando, Farber, Feuer, and Wortman, manuscript in preparation, for an approach to assisting trauma survivor clients in developing social support.) The work of building a therapeutic relationship, addressing disrupted cognitive schemas related to self and others, and processing trauma-related affect is described in numerous volumes written for therapists (e.g., Allen, 2001; Briere & Scott, 2006; Cloitre, Cohen, & Koenen, 2006; Courtois, 2010; Courtois & Ford, 2009; McCann & Pearlman, 1990a; Pearlman et al., manuscript in preparation; Najavits, 2002; Ross & Halpern, 2009; Saakvitne, Gamble, Pearlman, & Lev, 2000).

Trauma therapists who work with clients who have developed complex trauma adaptations are familiar with this work. What may be less familiar is conceptualizing it as moral work. What are the client’s moral obligations to others? This conversation will be most productive when it builds on the empowerment of the client in his or her everyday life, as described above. What are the long-term consequences of the client’s concerns and the resolution of these concerns, for both self and others? The culture of psychotherapy is one of self-focus. The field has adopted this orientation, partly because of the self- (rather than self-in-community) focus of contemporary Western culture. Thus, broadening the focus to include others, both those who are and others who are not in the client’s “meaningful psychological environment” (Rotter, 1982), to include all living beings and the natural environment, must be done with sensitivity to the client’s capacity to expand his or her attention. This is a developmental process within the client, and within the therapy relationship, one that may evolve once the survivor client feels that the therapist recognizes and validates accumulated pain.

People who have been harmed by others may have limited empathy with others’ needs. Those with complex trauma adaptations (such as dissociation, affect dysregulation, somatization, identity problems, or relationship problems; Courtois & Ford, 2010) may have grown up in
survival-focused conditions, including childhood homes characterized by harsh or cold parenting, abuse, violence, or neglect, or in urban or ethno-political conflict zones. For these people, the capacity to empathize with others and even to prioritize others’ needs may be inadequately developed. (This is different from the people-pleasing or care-taking behavior that some survivors adopt in order to survive, which is typically based on fear of rather than empathy for others.)

To become a victor, then, can be construed to mean becoming someone who lives a life informed by empathy for self and others, using compassion and understanding of the world as a basis for acting on behalf of both oneself and others, and contributing to a society in which violence and neglect are no longer tolerated.

Of course self-focus is not limited to persons who have been traumatized. Those who have been wounded psychologically through inadequate understanding, acceptance, and compassion or other life injuries may also find it difficult to empathize with others whom they view as more fortunate. Groups that have been harmed, whether through scapegoating, discrimination, or violence, may not only find empathy difficult; they may actively harm others (Staub, in press).

*Attending to Countertransference and Vicarious Traumatization*

What are the trauma therapist’s moral responsibilities? What constitutes “right action” on the part of a trauma therapist? When asked these questions, two seasoned trauma therapists of my acquaintance immediately responded that the trauma therapist’s most important moral responsibility is to attend to his or her own needs and feelings in a way that precludes harming the client and instead promotes clinical goals. “Recognizing and confronting our own emotional reactions to our clients…is a special form of courage required of therapists more than of any
other group of professionals” (Doherty, 1995, p. 157). Paralleling the client’s feelings, the therapist’s needs and feelings are also likely to be stronger in trauma therapy than in therapy with non-traumatized persons.

My colleagues and I have written extensively elsewhere about the professional and clinical management of countertransference (the therapist’s responses to a particular client) and vicarious traumatization (the cumulative response to all of one’s trauma survivor clients and their trauma material) (McCann & Pearlman, 1990b; Pearlman & Caringi, 2009; Pearlman & Saakvitnet, 1995; Saakvitne et al., 2000). Additional, excellent contributions to the literature on countertransference in trauma therapies include, for example, those made by Dahlenberg (2000), Danieli (1984), Wilson and Lindy (1994), and Wilson and Thomas (2004). Here I will add some reflections on the moral dimensions of this matter, the aspects of the therapist’s reactions that affect others’ welfare.

Neglecting the effect that trauma work has on oneself can result in direct harm to clients. Pearlman and Saakvitne (1995) postulated that unaddressed vicarious trauma is a foundational element of sexual misconduct among trauma therapists. Various researchers have found that incest survivors are more likely than other therapy clients to become victims of therapist sexual misconduct (Armsworth, 1989; Broden & Agresti, 1998; Kluft, 1990; Pope, 1994; Pope & Bouhoutsos, 1986; Pope & Vetter, 1991; Somer & Saadon, 1999). This behavior may be related to unaddressed vicarious trauma. Short of this egregious outcome, therapists may harm clients in other ways. They may avoid trauma material, violate boundaries, fail to remember important therapy material, or otherwise mishandle treatment relationships (Dahlenberg, 2000; Pearlman & Saakvitne, 1995). Each of these behaviors has the potential to slow the client’s recovery and/or to re-injure the client.
A lack of awareness of countertransference can lead a therapist to attribute feelings and
dynamics to the client which in fact are the therapist’s. This misguided ascription can pose an
obstacle to progress in the therapy or create self-doubt and confusion in the client (Dahlenberg,
2000; Pearlman & Saakvitne, 1995). For example, early in one treatment, a therapist had a
depth negative reaction to an adult male client’s account of sexual abuse that he experienced as
a child. She felt repulsed by the details of the story and furious at the person who had harmed a
vulnerable little boy. She was overwhelmed by these feelings and did not acknowledge them,
perhaps wishing to protect the client or protect herself or simply being unable to figure out how
to do so. The next week, the client canceled his session. The therapist felt regret as well as some
relief that she would not have to sit with this man and feel these intense emotions again. The
client decided not to return to this therapist because he was aware of her disgust and anger, and
this reinforced the same feelings he held toward himself for being victimized for the past 30
years. Therapists, and people in general, may not process their reactions and may be unaware of
their origins, depth, meanings, and ramifications. To act in an effective and moral way requires
such awareness, one of the important demands on a therapist. Effective clinical work also
requires self-awareness on the therapist’s part.

Dahlenberg and Brown (2001) addressed ethical issues in the treatment of child crime
victims. They noted that certain adaptations to childhood maltreatment, “such as sexual
promiscuity or sexual acting out (Burgess et al., 1987), suicidality (Bryant & Range, 1997), and
disorders of attachment that lead to manipulative or dishonest behaviors on the part of child and
adult clients (Briere, 1992)” may be “morally complex” (Dahlenberg & Brown, p. 2-1). These
typical adaptations may present challenges to a therapist who finds them morally questionable, a
stance that will inhibit the client’s disclosure and thus the dyad’s ability to explore, understand,
and address these behaviors. Attempting to contextualize these behaviors, extending compassion, and suspending judgment until one can understand, helps therapists and people in all relationships connect to each other more effectively. This process is a moral demand of psychotherapy: to use one’s reactions to promote the client’s well-being.

A clinical guideline for using countertransference constructively is to notice or name it, process it in consultation with a colleague, and then use it to advance the therapy (Pearlman & Saakvitne, 1995; Saakvitne et al., 2000). We must consider the implications of our thoughts, feelings, and actions for the client. Our responses have implications for the client’s view of himself, as well as his own behavior toward himself and others. If the therapist treats the client badly, or immorally, which could include engaging in sexual or social behavior with a client, disregarding the client’s privacy or confidentiality (by the former, I mean, for example, sharing details unnecessarily even with persons for whom one has written client consent), judging the client’s behavior without understanding or helping the client understand the behavior in its context, refraining from addressing concerns related to the client’s or his or her children’s safety, or shaming or humiliating a client. Some of these behaviors seem less subtle than others, and all can harm the client and perhaps cause the client to harm others. These “therapeutic errors” can reduce a client’s sense of self-worth, rob him of the ability to develop a potentially therapeutic trusting relationship with the therapist, re-enact the betrayal he may have experienced in other relationships, or allow him to continue to engage in harmful behavior.

The Trauma Therapist’s Moral Evolution

In addition to the possibilities for client growth, trauma therapists also have an opportunity for moral growth and expansion as a result of their work. “Psychotherapy at its best…can be a profoundly humanizing experience that increases our [therapists’] moral capacity”
(Doherty, 1995, p. 19). This is particularly true for therapists working with trauma survivor clients, who have undergone deep moral and spiritual violations. (I use the term “spirituality” to refer to an awareness of ephemeral aspects of existence. My colleague, Debra Neumann, and I developed this definition for use in [unpublished] interview research on spirituality in the early 1990s.) Despite the myth of neutrality (Kottler, 2010; London, 1986), all of us bring our own moral and spiritual perspectives to every encounter. In this section, I will trace a possible moral developmental progression that a trauma therapist might experience in his or her work with traumatized clients.

A natural beginning response to learning about the terrible experiences of victimization endured by many clients is shock, which may be followed by disbelief, disgust, and/or great sorrow. Of course these reactions temper over time. Without a personal trauma history (which many trauma therapists have; see, for example, Pearlman & MaxIan, 1995, and Wilson & Thomas, 2004), shock at deeds that harm doers commit is almost inevitable, and the shock can grow as the number of stories and their awful details mount. While therapists have heard about child abuse, neglect, emotional victimization, and other harmful deeds perpetrated against children, there is something deeply disturbing about sitting with someone who is recounting such experiences in detail, coupled with a responsibility to help. Our hearts must be open to our clients’ pain if we are to be effective, and an open heart is also open to injury. The open-hearted therapist is likely to feel some of the client’s pain. The moral concomitant of this response is usually a judgment against the inflictors of the harm. Over time, this judgment may expand to include those who stood by passively at the time when they might have prevented the harm, those who responded unhelpfully or harmfully, and a society in which such deeds, even today, are often accepted as an unfortunate but inevitable part of child-rearing. This social acceptance
of the victimization of children is evident in a thirst for violence that is partially sated through popular culture—movies, television shows, sports events, music that promotes violence—as well as our refusal in the U.S. to pay for adequate psychotherapy for abuse survivors.

Therapists working with survivors of interpersonal violence commonly develop feelings of personal vulnerability. Therapists who are parents often focus that vulnerability on the safety of their children. Many trauma therapists feel increased personal insecurity in the world, knowing that violence is often random and that they, too, could be harmed (assuming that this has not already happened in the therapist’s life). These feelings are uncomfortable, and can become intolerable. One quick-fix defense against these feelings is to blame the victim. This blaming can take subtle forms, such as thoughts about the victim having done something wrong or being in the wrong place at the time of the violence or the therapist being different from (and therefore less vulnerable than) the client (e.g., “She shouldn’t have been walking alone in the park,” “Child abuse happens only in chaotic families,” “Between my Tai Chi training and my ability to remain calm under pressure, I could protect my child in any situation”). These thoughts may help the therapist manage her fears, but they also reflect negative judgments about survivors, who are in fact not responsible for the actions of harm doers. Children growing up under threat often develop laser-sharp attunement in environments where moods and meanings can change rapidly and dangerously. Thus, they are likely to sense victim-blaming, however subtle, unconscious, unintentional, or well-disguised. When this occurs, the client will not likely develop the trust in the therapist that is essential to engaging in treatment authentically and benefiting from it. This is a moral malfunction on the therapist’s part, depriving a person who is suffering of services that might help him or her recover.
An alternative to victim-blaming is to find other circumstances that might explain the victimization that have nothing to do with the client but serve to protect the therapist from imagining himself the victim of a random traumatic event such as an assault or natural disaster. Janoff-Bulman (1998) pointed out humans’ reluctance to acknowledge the role of chance in extreme misfortune because it can open us to unmanageable fear of our own vulnerability.

Therapists may, consciously or not, use other defenses to protect themselves from this insecurity and the fear that accompanies it. These self-protective behaviors include, for example, tuning out when clients are talking about painful material, forgetting important things the client has said, missing or running late for appointments, not returning client phone calls, and so forth. While none of these actions can be categorically termed a defense, any of them could serve that purpose. Clients with childhood trauma histories, who are already prone to feel confused, guilty, responsible, inadequate, or even toxic, may feel this way even more as a result of defensively and unintentionally inconsiderate therapist behaviors. The therapist’s defenses may suggest to clients that there was something they could or should have done or known that might have protected them from victimization. Or they may feel that the therapist is avoiding them because they are “too much,” a common concern for people who grew up in homes where their needs were not met.

At the beginning of working with clients who have endured interpersonal violence or victimization, a therapist may feel angry about these violations. This anger may grow with each new report of selfishness, neglect, intentional harm, and cruelty. The therapist might express her anger at the perpetrators, disparage them in her speech, or paint them as bad, or even inhuman, people. In a consultation group for trauma therapists, after hearing the horrible details of childhood abuse that yet another client had reported to her therapist, one of the participants
suggested, with mild sarcasm, that the group swap names of their clients’ perpetrators and each participant hunt down and harm one of these despised individuals. This suggestion elicited an enthusiastic chorus of agreement, as well as uneasy laughter at their own frustration and sense of being overwhelmed arising from vicarious trauma: too many awful stories resulting in way too much pain, coupled with feelings of helplessness. The laughter also reflected some discomfort with even holding a fantasy of harming others, signaling to the therapists how much the work had changed them, as the subsequent discussion revealed.

Anger is very organizing, and helps people move from feelings of vulnerability to feelings of strength. While this anger toward harm doers is often wholly justified, it can reduce them to one-dimensional figures and constrain the ability of both the therapist and the client to understand these individuals’ complexities, including the harm doer’s motivations and history, and the social forces that surrounded the victimization. A less complex understanding (“he’s bad”) eliminates the client’s potentially contextualizing his victimization, reducing the likelihood of eventually making sense of and integrating his experiences of harm. This reaction also affects the ability of the therapist to help the client move from victim to moral agent, as discussed above. This sort of expanded understanding also applies in other sorts of interpersonal relationships. The more we understand each others’ behaviors in context, the more likely we are to feel empowered to act on our own and others’ behalf.

Vicarious trauma can itself result in moral judgments and consequent behaviors. Someone must be eliciting the bad feelings, the cynicism, the despair, the emotional reactivity that the therapist is experiencing. Without the theoretical framework of vicarious trauma (constructivist self development theory; McCann & Pearlman, 1990a; Pearlman, 2001; Pearlman & Saakvitne, 1995), one may attribute these difficulties to the wrong source. That source could
be one’s work setting and its leaders. In my experience leading workshops on vicarious traumatization, it is very common for participants who work in social service agencies to view the organization as the primary cause of their work-related stress and distress and the administrators as the enemy. Within a trauma-focused organization, the victim-perpetrator-bystander dynamic (Miller, 1994) is a highly available template for understanding group dynamics. While the stressors of agency work should not be minimized, the extent to which administrators are demonized is often excessive. Social service agency administrators work under very challenging conditions of shrinking budgets, growing waiting lists, demanding boards or public overseers, and, yes, sometimes hostile staff. Disgruntled staff members have been known to engage in subtle or overt denigration and sabotage of administrators out of their own sense of victimization. I would suggest that this is often a moral error, arising from a narrow focus on one’s own experience (occluding that of the administrators) and the need for a scapegoat.

How does the therapist respond to an adult who acknowledges that he harmed someone more vulnerable while he was a child in an abusive context, or that he has harmed others in adulthood? When such information emerges in a therapy relationship in which the therapist has known only of the client’s victimization, the therapist may experience a crisis. She now needs to expand her view of the all-good, innocent victim, to include behaviors that she judges as bad. The therapist may feel confused. One possibility is that the moral formulation shifts to “People who have been harmed by others are capable of doing harm.” Alternatively, or eventually, her moral formulation may expand to “Everyone is capable of harming others.” This latter stance of course includes potentially enormous growth, including “I am capable of harming others,” which usually is modified to a tolerable concept by “under certain circumstances.” This may feel
morally repugnant, or more likely, narcissistically injurious. As it is not possible to live up to our ideals at all times, we must develop ways of comprehending our own lapses. Perhaps we can do so in a way that also broadens our compassion for others when they inevitably fail to meet our or their own moral standards.

Clients can benefit from seeing their therapists struggle, and from struggling with them, with the desire for revenge and the wish for a more considered, compassionate, and complex way of understanding and responding to harm doers [for a discussion of this issue beyond the psychotherapy setting, see Pumla Gobodo-Madikizela’s (2003) wonderful account of her interviews with Eugene De Kock, one of the masterminds of apartheid in South Africa]. Those who engage in violence, abuse, and neglect are responsible for their actions and must be held accountable. At the same time, it is possible to understand such actions, and understanding does not imply accepting or forgiving them. Some excellent examples exist of complex frameworks for understanding perpetrators of group (Staub, in press) and individual (Athens, 1992) violence. Ervin Staub and I have worked in East Africa to promote understanding of harm doers through a public education project, in the hopes of helping all parties recover psychologically and preventing future violence (Staub & Pearlman, 2006). Previous research on the effects of understanding on orientation to a formerly hostile group found positive results in a community group context (Staub, Pearlman, Gubin, & Hagengimana, 2005).

A next step in the therapist’s moral development would be something like this: “While harm doing is wrong, those who harm others deserve compassion and the opportunity to process, acknowledge, and make amends for their deeds.” They must also engage in justice processes, taking responsibility for harm done.
A strong sense of right and wrong is often accompanied by clear lines between us and them. As moral judgments become more complex, this distinction begins to break down. In terms of the therapist’s moral evolution, the next step is the discovery that there is no “them.” It entails the therapist revising some of the usual categories and making more discerning judgments about who or what is right or wrong, based on a broader understanding of how wrong behavior comes about (see Baumeister, this volume, Staub, this volume). As Kohlberg suggested, moral development involves an expanding circle of role taking, considering events from many perspectives. At the extreme it might mean considering the perspectives of perpetrators.

Few people are capable of operating in the world with such a broadly inclusive morality. Its exemplars would be such figures as the Buddha, the Dalai Lama, Gandhi, Jesus, and Mohammed. The fact that these figures are exemplars underscores the rarity of the ability to live as if we are all “us.” This does not imply that there is no moral responsibility, or that we are not to pass judgment on others. While it is important to try to see the humanity in everyone and to comprehend people’s actions, it is also essential to take a stand against harming others. This means that while we attempt to understand and empathize with everyone, we also act in the world rather than withdrawing from it. Certain actions are reprehensible, even if they are accepted within a culture or understandable in the context of people’s lives. For example, harsh treatment of children is wrong because it dehumanizes and injures them.

Relinquishing “us vs. them” invites a therapist to consider his or her own potential to harm others. This moral expansion of the therapist can result from actively struggling with the horrors of interpersonal violence. It can be viewed as a vicarious transformation arising from engaging with one’s own vicarious traumatization.

Conclusion
This chapter has explored various moral dimensions of trauma therapies. Many of these processes are universal, applying to all human relations. We can all grow from our own and others’ responses to life experiences. Given the power of trauma therapies to shape people’s behavior toward others, it is valuable to consider them from a moral perspective. Doing so may provide opportunities for greater growth in clients and therapists alike.

References


