Controlling Empathic Imagery

Babette Rothschild

Therapist burnout is a pressing issue and self-care is possible only when therapists actively help themselves. In Babette Rothschild's new book, Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma (WW Norton, March 2006 £18.99), she explores the psychophysiology of compassion fatigue and vicarious trauma, and offers skills drawn from several models to support the therapist and minimize negative effects. In this extract, she looks at controlling empathic imagery.

Imagining the stories we hear from clients can boost empathy with them. However, it can also cause problems. Visualizing the distressing and traumatic events of others puts us into the position of 'eye witness'—one of the categories in the DSM IV that qualifies for posttraumatic stress disorder. Moreover, many who habitually imagine client stories (consciously or unconsciously), do so in the first person, as if it was happening to them (Maxfield, 1997). Obviously this is not a problem for some therapists. But if it is a problem for you, some simple, common sense interventions will help to put you in charge of your imagery.

Following his graduate studies Bob worked at his local Veteran's Administration, first as an intern and later as a staff psychologist. He had never been in the armed services himself, but he enjoyed the opportunity to provide service to the VA. However, when he married and began his family, he felt the need to earn more money

and left the VA to go into general private practice. That did not end his ties to the military, though, as yearly he received several referrals—from the VA and privately—of military personnel: enlisted and officers, those actively serving as well as veterans.

During the first eight years of his therapist life Bob heard many accounts of the kinds of horrors that military men and women face during war and peacetime. He thought he managed well. During the 2001-2002 war in Afghanistan, though, he began to 'work overtime.' He often found himself thinking excessively about his military clients during his free time. He also became edgy and developed sleeping difficulties, sometimes waking from nightmares of war.

Bob struggled a long time, trying to figure out why his client's stories were getting to him now. One evening, while watching the news, he had an epiphany: The pictures he saw of the Afghan war, were similar to the ones he was seeing in his dreams with his client's faces. The next day he realized that as he was listening to his client's experiences, he was picturing them in his mind's eye, using film clips from the news as his template.

A sense of control — mastery over one's world and mind — is essential for minimizing the negative risks of helping distressed people. Being in charge of the imagery in your own mind is a major step in that direction. A few simple interventions can give any therapist a secure sense of control over what are often judged as uncontrollable intrusions.

To Picture or not to Picture…

This illustration typifies how a common practice that aims to enhance therapist performance can actually detract from it.

Therkild was a counselor for a Holocaust project. As a part of his job, he conducted sessions with Holocaust survivors, detailing their experiences, and helping them make sense of their lives. The stories he heard were, of course, horrific. Therkild believed that this project was highly significant, and he was proud to participate. However, he regularly suffered as a result. Though he wanted to continue with this work, he was having increasing trouble sleeping and bouts of severe agitation (hyperarousal)—typical symptoms of vicarious traumatization. Moreover, he was becoming hopeless about the future—a common symptom of burnout. He knew the source of his difficulties, but did not want to quit. On the advice of a friend, he sought consultation.

With help, Therkild was able to zero in on his vulnerable points. Among other issues, the consultant identified Therkild's habit of visualizing the stories he was being told as a possible source of his difficulties. Therkild felt it was his duty to try to imagine what his clients had experienced. He would consciously visualize during sessions, trying to see the details of the horrific events the client had gone through; he hoped it would make him a more sensitive counselor. Unfortunately,

however, the images he conjured during the interview sessions continued to appear unbidden at other times, often in his dreams. He was not able to shake the pictures or the feelings they stirred in him.

The consultant suggested Therkild might examine whether his habit of visualization actually enhanced his abilities as a counselor. They discussed the common (mis)assumption that 'trying on' the other's experience would be helpful. It was the consultant's notion that this was not necessarily the case, that this practice could actually hamper Therkild's ability. At the least, he was suffering because of it. The only way to know if visualization was the key to his vicarious trauma was to make an experiment: try it both ways, alternating from session to session. He was instructed to pay attention to his body awareness and emotions before and after each session. Only then would he be able to determine what was best for him.

They agreed that for the next week, Therkild would keep his visual focus in the room for some sessions and continue to visualize for others. He would keep a log of what happened from session to session. Ahead of time they discussed strategies to help keep Therkild alert in the here-and-now if he found himself falling into habitual visualizations. He suggested that paying closer attention to the client's words and gestures, and periodically looking around the room, would be helpful in keeping him focused. During the session, Therkild listened to his clients as always, and asked appropriate questions. For half of the sessions he was mostly able to refrain from making pictures in his mind, relying on the strategies he and his consultant had come up with.

Though he felt a bit awkward in restricting himself, Therkild noticed a difference immediately. He did not become nearly as anxious as usual during sessions where he was not visualizing, and he was much calmer after those sessions. He had no doubts that what had been described had been horrific, he felt very sympathetic. But, without visualizing along side, he was not suffering with *those clients. The first night of his experiment he slept more peacefully than he would have expected. Moreover, in reflecting back, he judged that even the sessions where he had kept from visualizing had gone as well as usual. During those sessions he had actually remembered a couple of important questions that he often forgot.*

After a week of experimentation, Therkild weighed the pros and cons of visualizing his client's stories. He concluded that, for the most part, he would permanently change his habit and stop requiring himself to see the stories. He knew he could still use that tool if there was something he could not otherwise understand. But generally he wanted to relieve himself of that added stressor.

This simple change was rather easy for Therkild to apply because, for the most part, his habit of visualization had usually been voluntary; he had chosen to create imagery. This is not

always the case. Some therapists find themselves visualizing the circumstances of clients reflexively. Halting an unconscious habit is a little more involved as will be shown Tina, below.

Controlling Uninvited Images

This next example involves techniques which are inspired by neurolinguistic programming's (NLP) concept of *submodalities* (Bandler, 1985; Andreas & Andreas, 1987). The idea is simple. The goal is to take control of any visual or auditory images that are invoked when hearing (or thinking about) distressing stories or reports. By changing elements of the images (the submodalities) they can be managed.

Tina had been a therapist in a Rape Crisis center for about a year when she realized her life style was getting more and more restricted. Though she had never suffered physical violence, she was finding herself behaving and feeling in ways similar to many of her clients. Of course, as most who work with victims of violence, Tina had become more aware of danger and more cautious. But in the last couple of months, what had been sensible caution had crossed the line into debilitating limitations. She decided she needed counseling and engaged a psychotherapist.

Tina told her new therapist that she was behaving more and more as a raped woman and that scared her very much. She had also had a few anxiety attacks (heart racing, cold sweating, disoriented) while out at night and was becoming more and more concerned The therapist helped Tina to understand the concept of vicarious traumatization, and suggested they find out what her special vulnerabilites were. Among other things, the therapist focused closely on how Tina processed the information she was given by her clients, particularly how she 'heard' their experiences of Rape.

'Oh, I don't just hear it,' Tina replied, 'I see it.' Upon close scrutiny, the therapist learned that images of the client's rapes automatically appeared in Tina's mind's eye. She never planned to visualize the rapes, 'it just happens.' Actually, it was the one aspect of her job that she hated. Tina loved helping the women (and the occasional man), but she dreaded the images that would then fill her head.

The psychotherapist believed there was an additional compounding factor. It was Tina's tendency to visualize her client's rapes in the first person, as if it was happening to her, rather than as an observer.

This is a common occurrence with visualization (Maxfield, 1997). While first person imagery can be useful in learning a new skill or sport, it actually can compound the therapist's risk for vicarious traumatization. Of course it is a good idea to control imagery that is obviously distressing to you—during a session, immediately following a session, or between sessions with your client. If in doubt, being mindful and taking stock of your arousal level during sessions and when a client leaves, can be helpful. As we will see in the

examples below, it is common for psychotherapists to believe that visualizing client stories enhances empathy. Actually, that is probably correct. *But at what cost?* And is visualization necessary to empathy? Probably the answer to that varies from practitioner to practitioner, and perhaps also client to client. There is always a fine line to walk: maximizing useful empathy without endangering the mental health of the practitioner. For each of you the balance will be slightly different, an individual matter for you to negotiate for yourself (and/or with the help of a consultant or your own therapist). Below are several exercises which will those readers with this tendency. First, back to Tina.

Her therapist suggested that Tina could gain control of the images in her mind's eye. Tina was a bit dubious, but was willing to try anything to feel better and be able to continue in her job. They did not jump directly to working with the debilitating, frightening images. Initially, they worked with neutral and positive images. The therapist first had Tina visualize a blue ball twelve inches in diameter floating just in front of her chest three feet away. Then the therapist instructed Tina to change aspects of the visualization—different color, distance, size, shape, etc.—changing one 'submodality' at a time. When Tina became confident in her ability, the therapist gave more complicated instructions. Finding she was able to manipulate these simple images boosted Tina's confidence.

At this point it is relevant to mention that had Tina's (or Therkild's, for that matter) images been of an auditory or tactile nature, these same interventions could be used changing the instructions to focus on sounds or skin sensations instead visual images. The effect can be the same, though the adaptation of the instructions might be a bit more challenging. Sometimes the images are not actually *seen*, but more *felt*. In those instances the instructions can also be adapted to, for example, '*Sense* a twelve-inch blue ball in front of you. *Feel* it shrink in size,' etc.

At the next session they continued to train Tina's sense of control. The therapist suggested that Tina choose a non-traumatic activity she had observed. As she liked to watch the Wimbledon Tennis Championship, she chose that. It was a plus for the purposes of the exercise that Tina did not actually play tennis. That way she could experiment altering her first-person image with an activity her body did not actually recognize, just as she would eventually do with imagining a rape which she had (thankfully) also not experienced.

The therapist instructed Tina to start with one view—that of the player or that of the observer—and periodically switch her perspective. First she would imagine playing the game, how the swing of the racquet would feel, or moving on her feet. Then she would change and imagine observing someone else play the game as she did while watching T.V. The idea was to have her experience controlling the

imagery, without the stress of upsetting content. Once she became skilled at controlling images in this way, she could graduate to controlling the images that had been plaguing her.

This entire process took several weeks. Applying it in her working situation was gradual. At first Tina would practice being an observer, rather than a participant in her mind's eye. Eventually, she learned that she could visualize other things when hearing the stories of rape. As Therkild learned, above, Tina also found she did not have to picture the violence to be sensitive and empathetic to what her client had experienced.

EXERCISES

If you think you could benefit from one or more of the above strategies in your own work, here are a couple of exercises you can try. Remember, if you are not someone who has visual images, you can try the same procedure with the kinds of images you do have: auditory, tactile, body position and movement, etc.

Imagery Control Exercise 1

In your mind's eye, imagine an everyday object. It does not matter what it is, so long as it is not associated with stress. If you are not able to visualize, do not worry. Many people do not visualize. You are welcome to alter the exercise exchanging 'feel' or 'sense' for 'see' or 'visualize.' As well, exercise #2 will involve auditory images. As Tina did above, manipulate your (visual, sensory—whatever) images of the object in as many ways as you can think of. Change its size, distance, color, shape, etc.

Imagery Control Exercise 2

Imagine you have a tape recorder beside you with a good selection of controls for altering submodalities: volume, speed, pitch, direction, etc.

Choose something neutral or pleasant to start with: a song, dialogue from TV, a story read aloud, etc. Then play around with altering its features. Make it louder, make it softer. Raise and lower the pitch. Play it backwards, play it forwards. Try changing the speed. You can also change the voice to another speaker—Mickey Mouse, Donald Duck, Elmo—any voice you like.

Next you can try the same tools with a sound or voice that has some emotional meaning for you. Just make sure to *gradually* increase the difficulty or emotional charge of the voice/sound you are working with. Do not go to the next level of challenge until you have mastered the level you are at.

This is also a great technique for those who are plagued by critical voices in their heads. Just change the critical voice to Elmo or Mickey Mouse and see if the criticism has the same sting.

It is equally useful, say, for the abuse therapist who can not get the sound of crying children out of his head, or the veteran's counselor who keeps hearing gunfire. Learning to take command of the audio controls can help these distressing sounds, and others, that are

replayed in your mind to diminish or even disappear.

Imagery Control Exercise 3

Practice 'watching' a pleasant or neutral image on an imagined TV monitor. Assume you have a full set of controls for making the picture larger, smaller, changing the focus, changing the color palette, moving the TV closer or farther from you, turning the sound up and down, turning the picture on and off, etc. One at a time, experiment with changing as many of the features (submodalities) as you can.

Once you become adept, you can try images that have more emotional meaning for you. Just make sure to take your time and *gradually* increase the difficulty of the images. Do not move on to something more potentially upsetting before you have mastered control of a less stressful image.

Eventually, you can try the same thing with images from your work that have or do plague you. When you find yourself imagining something horrible that you are being told about, move the screen further away, blur the image, step out of the first person into the observer, look at something else, turn off the image altogether and just listen to your client. The idea is to reinforce for yourself that *you have full* choice over if and how much you will 'try on' or 'witness' the experiences of your clients.

References

Maxfield, L.. Advanced clinical interventions: A training manual for work with survivors of trauma, abuse, and violence. Thunder Bay On: Author. (1997)

Bandler, R. Using your brain for a change. Moab, UT: Real People Press. (1985).

Andreas, A, & Andreas, T (1987). Change your mind and keep the change: Advanced NLP Submodalities Interventions. Moab, UT: Real People Press.

Babette Rothschild is the author of the bestselling The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment, as well as The Body Remembers CASEBOOK, along with Help for the Helper—all published by WW Norton. At home in Los Angeles Babette maintains a small private practice and provides long-distance supervision around the globe. She also gives professional trainings and lectures worldwide, including an active schedule in the UK. She can be reached at: babette@trauma.cc.